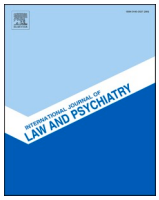
International Journal of Law and Psychiatry 107 (2026) 102224

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

journal homepage: www.elsevier.com/locate/ijlawpsy



Research Paper

Barriers and facilitators for mental-health professionals in the management and implementation of advance directives

Sergio Ramos-Pozón [a], Anna Falcó-Pegueroles [b,*,1], Silvia Poveda-Moral [a], Hilari Andrés-Mora [c], Raquel Fabregat-Marcos [c], Ramon Mir-Abellan [c], Luisa Baladón-Higueras [c], Begoña Roman [d], Bernabé Robles [c], Eva Garrido-Aguilar [a]

[a] Faculty of Nursing, University of Barcelona, Spain
[b] University of Barcelona, Spain
[c] Parc Sanitari Sant Joan de Déu, Barcelona, Spain
[d] Faculty of Philosophy, University of Barcelona, Spain

ARTICLE INFO

Keywords:
Advance directives
Mental health
Bioethics
Law
Human rights

ABSTRACT

Background: The Advance Directive (AD) serves as a fundamental legal and ethical instrument for safeguarding patient autonomy, ensuring that clinical decisions align with individual values when decision-making capacity is compromised. Despite the established legal framework in Spain since 2002, its practical implementation within mental health services remains largely under-researched. The objective of our study is to describe the barriers and facilitators perceived by mental-health professionals regarding the clinical management and implementation of the Advance Directive (AD).

Methods: A descriptive, cross-sectional study was executed between December 2022 and March 2023 at Parc Sanitari Sant Joan de Déu (Barcelona, Spain). The sample comprised 215 healthcare professionals across various disciplines—including nursing, psychiatry, psychology, and social work—representing a participation rate of approximately 20% of the 1035 eligible institutional staff.

Findings: Results reveal a profound discrepancy between theoretical appraisal and clinical practice. Although 96.7% of professionals acknowledge the utility of the AD, practical engagement remains residual: only 20.0% of participants report direct experience with a patient's document. Critical operational barriers were identified, as 74.4% of respondents were unfamiliar with procedures for retrieving an AD from the official registry. Furthermore, 71.6% of professionals perceive an absence of adequate technical or administrative resources provided by their institution. Conversely, facilitators are rooted in ethical commitment; 88.3% maintain that a patient's anticipatory wishes should be respected even when they conflict with clinical advice.

Conclusions: Findings underscore a significant gap between the ethical-legal ideal of autonomy and its clinical execution within the Spanish mental health context. Positive professional attitudes are insufficient without robust systemic support. Effective implementation necessitates a multidimensional strategy: strengthening specialized continuing education, streamlining access protocols within electronic health records, and fostering institutional policies that prioritize patient-centered psychiatric care.

* Corresponding author.
E-mail addresses: sergioramos@ub.edu (S. Ramos-Pozón), annafalco@ub.edu (A. Falcó-Pegueroles), s.povedamoral@ub.edu (S. Poveda-Moral), hilari.andres@sjd.es (H. Andrés-Mora), raquel.fabregat@sjd.es (R. Fabregat-Marcos), ramon.mir@sjd.es (R. Mir-Abellan), luisa.baladon@sjd.es (L. Baladón-Higueras), broman@ub.edu (B. Roman), b.robles@pssjd.org (B. Robles), evagarrido@ub.edu (E. Garrido-Aguilar).
[1] Departament de Fundamental and Clinical Nursing. Faculty of Nursing. University of Barcelona Governing Pavilion, 3rd floor, Feixa Llarga office, s/n. 08907 L'Hospitalet de Llobregat (Barcelona, Spain).
Consolidated Research Group (SGR) 353 Bioethics, Law and Society: Interdisciplinary analysis of ethical, legal and social issues of biomedicine, biotechnology and emerging technologies (BIOELSi). University of Barcelona

https://doi.org/10.1016/j.ijlp.2026.102224
Received 3 October 2025; Received in revised form 9 February 2026; Accepted 26 March 2026
Available online 1 April 2026

1. Introduction

The Advance Directive (AD) is a legal document that allows patients to state in advance their preferences regarding medical care and treatments. It also enables them to designate who will make decisions when they are unable to do so themselves and, if they wish, to record consent for organ donation. As an instrument, it ensures that the patient's values and beliefs are respected and that decisions are taken in their best interests. These documents are a legitimate means to give effect to obligations arising from the Convention on the Rights of Persons with Disabilities (Bianchi, 2020; Lenagh et al., 2023). The literature shows that the vast majority of health professionals support the introduction, application, and respect of a person's advance decisions in clinical decision-making (Poveda et al., 2020; Poveda, De la Casa, et al., 2021; Poveda, Falcó-Pegueroles, et al., 2021; Schiffman & Werner, 2017). The introduction of peer support specialists—individuals with lived experience of mental illness who are trained to support others—may be a useful resource to assist patients in Advance decision-making (Belden et al., 2022; Easter et al., 2021).

In many countries, advance decisions are governed by specific legislation (Gloeckler et al., 2025; Redahan et al., 2024). Examples include the Mental Capacity Act 2005 (United Kingdom), the Mental Health Act 2014 (Australia), the Health Care (Consent) and Care Facility (Admission) Act (Canada), and the Mental Health (Care and Treatment) (Scotland) Act 2003, among others. In Spain, Law 41/2002 on patient autonomy and rights and obligations regarding clinical information and documentation has regulated the AD for over 20 years; however, awareness of the AD among patients, families, and professionals remains unsatisfactory (Contreras et al., 2015; Contreras et al., 2017; Fajardo et al., 2015; Herreros et al., 2020; Schiffman & Werner, 2017). The latest official figures report 561,517 registered ADs, a rate of 11.56 per 1000 inhabitants (Ministry of Health, 2025).

In Spain, although Law 41/2002 on patient autonomy has been in force in Spain for over two decades, its implementation remains critically insufficient. This is partly due to a primary obstacle: a deficit in professional knowledge. More than 90% of healthcare staff report a lack of clear information regarding the legal content or the specific mechanisms required to consult these documents (Porcar et al., 2021; Poveda et al., 2021). This landscape is further exacerbated by a deficient administrative infrastructure. Complex bureaucracy and disparate registration systems across Autonomous Communities render the formalization process slow and cumbersome (Herreros et al., 2020; Porcar et al., 2021). Moreover, even when an Advance Directive (AD) exists, its clinical utility is often compromised; documents frequently contain imprecise instructions or prove difficult to access during emergencies. These factors, compounded by time constraints and litigation anxiety, foster a climate of “defensive medicine” that tends to disregard the patient's stated will (Porcar et al., 2021; Poveda et al., 2020). On a social level, the adoption of ADs encounters significant socioeconomic and cultural barriers. Usage is notably lower among populations with limited income or lower educational attainment and is frequently restricted to oncology contexts, neglecting neurodegenerative pathologies (Dalmau et al., 2022). Furthermore, within Mediterranean cultural paradigms, a paternalistic model still prevails, prioritizing the judgment of families and physicians over written directives. This often leads to the erroneous conflation of advance planning with patient abandonment or euthanasia (Dalmau et al., 2022; Herreros et al., 2020).

Several barriers may account for this, including lack of professional training, scepticism about utility, beliefs that patient preferences could lead to poor clinical outcomes, concerns that representatives may not decide responsibly on the patient's behalf, or that use of the documents might trigger conflict between patients and professionals (Glue, Thom, et al., 2020,Glue, Thomb, et al., 2020; Hotzy et al., 2020; Swartz et al., 2021). Nonetheless, Avila and Leeper (2022) show that these barriers can be overcome through accurate information and targeted training.

In mental health care specifically, multiple studies highlight the AD's particular utility, reporting substantial improvements in clinical, care-related, and ethical dimensions (Gaillard et al., 2023; Glue et al., 2020; Murray & Wortzel, 2019; Scholten et al., 2019; Stephenson et al., 2023). In times of crisis, psychiatric patients often prefer alternatives to hospital admission, such as remaining at home or receiving visits from a health professional. During admission, they may state preferences about which visitors they wish to receive or avoid. They may also specify dietary requests and ask that relatives or pets be cared for by a designated person. Perhaps the most frequent therapeutic choices concern refusals of certain pharmacological treatments or electroconvulsive therapy (Glue et al., 2020; Reilly & Atkinson, 2010).

However, beyond clinical or care-related considerations, anticipating and agreeing decisions with patients also yields empowerment benefits. Backlar et al. (2001) reported that patients who completed an AD experienced a greater sense of protection and satisfaction, knowing they would retain decision-making capacity during periods of vulnerability rather than relying exclusively on the clinical team. Respecting the patient's stated will reduces perceptions of coercive treatment, thereby facilitating collaboration throughout care (Tinland et al., 2022). Conversely, when patients experience a lack of respect for their autonomy in medical decision-making, they may feel excluded and treated unjustly, which can diminish adherence to recommended treatment (Glue et al., 2020; Glue et al., 2021; La Fond & Srebnik, 2002; Tekkalaki et al., 2018). Accordingly, advance decisions in mental health can substantially contribute to the humanisation of healthcare (Caraco et al., 2023).

In recent decades, multiple questionnaires with varied item formulations have been developed to quantify and analyze professionals' knowledge and attitudes regarding the AD (Aguilar et al., 2018; Ameneiros et al., 2013; Fajardo et al., 2015; Jiménez & Farouk, 2015; Rouco et al., 2015; Simón et al., 2008; Vázquez et al., 2020).

Domain-specific tools have also been developed for mental health settings (Elbogen et al., 2006; Juliá et al., 2019; Juliá et al., 2020; O'Connell & Stein, 2005; Srebnik & Brodoff, 2003; Wilder et al., 2007). These studies examine clinicians' perceptions of treatment refusal and hospital admission, the nature of their therapeutic relationships, and their knowledge of the AD. In short, they seek to generate relevant evidence on health professionals' attitudes and knowledge regarding patient autonomy and respect for stated preferences.

Despite these efforts, further research is needed to understand mental-health professionals' experience with advance directives. In Spain, the AD has not yet become firmly embedded in healthcare practice (Herreros et al., 2020), and literature focusing on mental health is insufficient to characterise the state of the field. It is therefore necessary to conduct studies that elucidate professionals' experience with anticipatory decision-making in mental health.

For all these reasons, we consider that the persistence of such barriers—more than two decades after the legislation's enactment—is particularly concerning within the field of mental health, where paternalism may be even more prevalent than in other healthcare areas. Consequently, this article does not merely aim to address a gap in the literature; it constitutes a necessary evaluation of the commitment to a more profound respect for the human rights of individuals with mental health conditions.

To our knowledge, this study is one of the first in Spain to specifically and comprehensively examine the perspectives, competencies, and perceived barriers of a multidisciplinary group of mental health professionals regarding Advance Directives. By focusing on the specialized field of psychiatry, this research addresses a significant gap in the national literature, providing original evidence that is essential for understanding the practical challenges of implementing patient autonomy in mental health care.

2. Objectives

To describe the barriers and facilitators perceived by mental-health

professionals regarding the clinical management and implementation of the Advance Directive (AD).

3. Method

This study, employing a quantitative approach and a descriptive cross-sectional design, was conducted following the recommendations of the STROBE Statement (*Strengthening the Reporting of Observational Studies in Epidemiology*) to ensure transparency and clarity in the description of the methodology, participant selection, data collection, and analysis of results.

3.1. Study design

Descriptive, cross-sectional study conducted from December 2022 to March 2023.

3.2. Setting and study population

The study was carried out in mental-health and psychiatry services providing care to people with mental disorders at Parc Sanitari Sant Joan de Déu, Sant Boi de Llobregat (Barcelona, Spain). The institution employs 1035 healthcare professionals: 469 staff nurses, 22 nurse case managers, 26 nurse supervisors, 331 physicians, 23 heads of service, 12 coordinating physicians, 96 psychologists, and 56 social workers. Its reference population comprises 672,465 people for community care, 1,832,098 for psychiatric hospitalisation (acute and subacute), and 2,465,231 people with intellectual disability and mental disorder.

All healthcare professionals who provided care to people with mental disorders were eligible, irrespective of professional category, clinical experience, or employment status. It should be noted that, from a total of 1035 eligible healthcare professionals invited to participate, 215 valid responses were ultimately collected. This corresponds to an approximate response rate of 20.8%. Although this rate is significant, the specific characteristics of the sample must be considered when interpreting the findings.

3.3. Sample size calculation

Non-probability convenience sampling was used. The sample size was estimated with the proportion equation, assuming a 95% confidence level and a 5% margin of error. The required potential sample was 281 participants. Furthermore, given the implementation of non-probability convenience sampling and the single-center design of the study, it must be acknowledged that our results primarily reflect the reality of the participating institution. Consequently, generalizability to other hospitals, mental health centers, or different international contexts may be limited. Therefore, these data should be interpreted as an exploratory insight into professional perspectives within this specific clinical context.

3.4. Instrument and data collection procedures

Phase one involved a literature review of validated questionnaires assessing professionals' knowledge and attitudes toward the AD in mental-health care (Aguilar et al., 2018; Álvarez et al., 2015; Ameneiros et al., 2013; Contreras et al., 2015; Contreras et al., 2017; Elbogen et al., 2006; Fajardo et al., 2015; Granero et al., 2016; Jiménez & Farouk, 2015; Jiménez & Farouk, 2015; Juliá et al., 2019; Juliá et al., 2020; Nicaise et al., 2015; O'Connell & Stein, 2005; Rouco et al., 2015; Simón et al., 2008; Srebnik & Brodoff, 2003; Thom et al., 2015; Vázquez et al., 2020; Wilder et al., 2007). For this project, a validated questionnaire was not used. Our aim was to describe the barriers and facilitators perceived by mental health professionals within a specific context; therefore, we developed an ad hoc instrument.

Based on this review, an initial ad hoc survey was drafted and evaluated by a 13-member expert panel spanning psychiatry, nursing, law, philosophy, and sociology. Experts were asked whether each item was appropriate for exploring healthcare professionals' barriers and facilitators regarding the AD in mental health, and whether items were brief, clear, and intelligible. They could propose additions or deletions. Items were then reformulated per the panel's recommendations, yielding a revised questionnaire, which was re-submitted to the panel for item adequacy ratings on a 9-point ordinal Likert scale (1 = extremely adequate; 9 = completely adequate). Each item included space for suggested modifications.

The final survey comprised 20 items grouped into three domains: professional barriers (knowledge and skills), organisational/structural barriers, and decision-making facilitators. Administration was self-administered online and required 10–15 min.

In phase two, authorisations were obtained from the Medical and Nursing Directorates, the Research Ethics Committee with Medicines of the participating centre, and the Bioethics Commission of the University of Barcelona. Information was disseminated to professionals and heads of service via email and routine work meetings. The information sheet, informed consent, and the survey link (REDCap) were distributed through corporate email. Data collection ran from 16 December 2022 to 20 March 2023, yielding 215 completed questionnaires.

3.5. Statistical analysis

Descriptive analyses were performed for participants' sociodemographic data and for each survey item, using means and standard deviations for numerical variables and frequencies and percentages for categorical variables. Statistical analyses were conducted with SPSS v27 for Windows. Analyses remained descriptive in line with the study's exploratory objectives; subgroup comparisons or inferential tests for differences were not conducted.

3.6. Ethical considerations

The study adhered to the principles of the Declaration of Helsinki. Researchers guaranteed anonymity, confidentiality, and data protection in accordance with current personal data legislation and digital rights (Regulation (EU) 2016/679 of the European Parliament and of the Council, 27 April 2016). REDCap survey design enabled anonymity and secure database management, accessible only to three members of the research team. To mitigate potential social desirability bias and the inherent discomfort associated with disclosing professional knowledge gaps, strict anonymity was maintained throughout the study via the REDCap platform. This methodological approach was designed to foster an ethically secure environment, thereby encouraging participants to provide honest and transparent self-reporting regarding their competencies. Participants received oral and written information about the study's purpose and affiliation. The project was authorised by the institution's Research Directorate and approved by the Research Ethics Committee with Medicines (PIC-134-22) and the University of Barcelona Bioethics Committee (IRB00003099).

4. Results

4.1. Sociodemographic characteristics

A total of $n = 215$ professionals participated. Of these, 31.2% ($n = 67$) were mental-health nurses, 4.7% ($n = 10$) nurse case managers, 20.0% ($n = 43$) psychiatrists, 9.3% ($n = 20$) clinical psychologists, 3.3% ($n = 7$) heads of service, 1.4% ($n = 3$) occupational therapists, 3.3% (n = 7) social educators, 6.5% ($n = 14$) social workers, and the remaining 20.5% ($n = 44$) from other, unspecified disciplines. Overall, 74.9% ($n = 161$) were women and 25.1% ($n = 54$) men, with a mean age of 43.2 years (SD ± 10.4). Mean years in professional practice were 17.7 (SD ± 9.2), and mean years in the same unit were 12.3 (SD ± 8.2).

4.2. Knowledge and skills for managing the advance directive

4.2.1. Knowledge

Overall, 53.5% (n = 115) reported knowing "some aspects" of the AD's meaning, while 27.9% (n = 51) considered they knew it "quite well." Regarding the legal framework, 81.8% (n = 176) knew that anticipating decisions through a AD is a right regulated by health legislation; only 9.8% (n = 21) were partially or totally unaware. Furthermore, 84.2% (n = 181) disagreed or strongly disagreed that complying with a AD would exempt the professional from all responsibility for the patient's clinical course, whereas 15.8% (n = 34) agreed or strongly agreed.

Concerning the formalization procedure stipulated in health legislation, 78.1% (n = 168) disagreed that a AD can only be made official before a notary. Of these, only 21.9% (n = 47) knew about other available options.

With respect to accessing AD registries for the patients they care for, 74.4% (n = 160) were totally or partially unfamiliar with how to retrieve a patient's AD swiftly. Only 12.6% (n = 27) knew how to access it—or how to do so in detail.

4.2.2. Skills

Regarding professionals' skills for managing the AD in the context of people with mental disorders, 65.1% (n = 140) felt prepared to help patients make anticipatory decisions, whereas 34.9% (n = 75) disagreed or strongly disagreed (27.9% and 7.0%, respectively) or did not feel prepared to assist their patients in deciding in advance. By contrast, 60.9% (n = 131) judged that, in general, mental-health professionals do not know how to help patients decide in advance; only 39.1% (n = 84) considered them prepared.

As to who should take the initiative to draft a AD, 34.4% (n = 74) partially or fully agreed that the patient should proactively request it, while 65.6% (n = 141) considered it the professional's responsibility to suggest it.

In routine practice, 46.1% (n = 99) believed they never or rarely counselled patients to decide in advance (e.g., what to do in case of a new crisis); 29.3% (n = 63) did so sometimes; and 24.6% (n = 53) did so often or always (17.2% and 7.4%, respectively). Only 20.0% (n = 43) of mental-health professionals had direct experience with a patient's AD, compared with 80.0% (n = 172) who had never or rarely (61.9% and 18.1%, respectively) encountered one.

4.3. Organisational and structural barriers to implementing the advance directive

A total of 93.5% (n = 201) agreed or strongly agreed (59.1% and 34.4%, respectively) that public authorities had not undertaken sufficient actions to raise public awareness of the AD. Consistently, 71.6% (n = 154) of mental-health professionals felt that their healthcare institution had not provided adequate technical and administrative resources to facilitate drafting ADs for their patients.

Conversely, 55.9% (n = 120) felt supported by their team or institution to carry out a AD.

4.4. Facilitators of the advance directive

Overall, 59.6% (n = 128) agreed or strongly agreed (49.8% and 9.8%, respectively) that the healthcare decisions of the people they treat are respected in all cases. Specifically, when patients' wishes are recorded in a AD, 88.3% (n = 190) agreed or strongly agreed (67.4% and 20.9%, respectively) that these wishes should always be respected, even when contrary to professional advice. In case of disagreement between patient and professional, 84.2% (n = 181) considered that the patient's view should always prevail.

Regarding utility, 96.7% (n = 208) stated that the AD is a very useful decision-making tool, chiefly because it enhances patients' sense of control over health-related decisions. Most respondents—95.8% (n = 206)—considered the AD the best strategy to ensure respect for patients' rights. Only 16.7% (n = 36) would not respect the AD in the event of clinical decompensation. Likewise, 95.3% (n = 205) agreed that the AD would help families better handle difficult decisions during crises and decide on the patient's behalf.

Although 97.2% (n = 209) believed that ADs may contain decisions that are hard to accept from a professional standpoint, 92.1% (n = 198) agreed or strongly agreed (61.4% and 30.7%, respectively) that the AD would lead to a better therapeutic relationship.

5. Discussion

Research on knowledge, skills, and barriers has frequently focused on healthcare professionals—psychiatrists, psychologists and nurses (Amering et al., 1999; Elbogen et al., 2006; Swanson et al., 2007; Van Dorn et al., 2006; Wilder et al., 2007).

In our view, this study broadened the traditional approach by incorporating not only conventional clinical roles but also diverse profiles within the mental health ecosystem, to obtain a more comprehensive perspective of the care environment. While previous research has frequently focused on general healthcare staff, it is worth noting that our article specifically examines the specialized experience of mental health nurses and nurse case managers, whose roles are crucial for the recovery of patients with mental illnesses. Furthermore, by including social educators and heads of service who coordinate care units, we address the organisational and leadership dimensions often neglected in the literature, which tends to prioritize a strictly clinical perspective.

Although many participating professionals appraised the AD positively, a large proportion had little practical experience with such documents. Prior studies confirm a discrepancy between favourable attitudes toward ADs and their actual use in mental health (Avila & Leeper, 2022; Juliá et al., 2019; Shields et al., 2014). This mismatch invites deeper exploration of causes and solutions, calling into question current training methods and professionals' preparedness to manage ADs.

Professionals and patients alike have limited knowledge of Ads (Avila & Leeper, 2022; Juliá et al., 2019; Shields et al., 2014). Notably, fewer than 20% of professionals in our sample had any contact with an AD, despite broadly favourable views. This is unsurprising given that only one third had ever attempted to counsel patients about anticipatory decisions, even though nearly 60% felt capable of doing so. Possible explanations include limited time per patient, the low priority given to ethical issues, or a predominantly biological focus at the expense of psychosocial and spiritual aspects (Jami et al., 2023).

Around 80% of our sample recognised that anticipating decisions through a AD is a patient right, and about 60% felt prepared to help patients decide in advance; nevertheless, nearly half had never or rarely tried to counsel patients on anticipatory decision-making. Such an attitude may reflect professional insecurities, stigma or a paternalistic culture in healthcare (Herreros et al., 2020). Coercive treatments offer a paradigmatic example (Aragonés & Sánchez, 2023). Negative preconceptions and reluctance may also arise in scenarios involving potential treatment refusal, especially medication refusal (Elbogen et al., 2006). Concerns about patients' decision-making capacity recur across studies (Shields et al., 2014).

High-quality training is essential to address these competency gaps and secure ethical, patient-centred practice among future professionals. Helen Yue-lai Chan et al. (2020) found that appropriate education in advance care planning increases professionals' willingness and confidence to discuss anticipatory decisions and reduces perceived barriers such as time constraints and cultural taboos.

Clear political and institutional guidance is likewise needed to support coherent, system-wide AD implementation in mental health. Training deficits are evident in our results: approximately 75% of professionals reported not knowing how to access a patient's AD. This

represents a significant operational challenge and a barrier to patient-centred care.

From our perspective, the inability of 74.4% of healthcare professionals to access advance directives is not solely attributable to individual ethical deficiencies, but stems largely from a structural and organisational 'invisibility.' We observe that these documents are poorly integrated into electronic health records; their location within the system is often inconspicuous, and their accessibility is frequently impractical during clinical crises. As a potential solution to these issues, we contend that institutions must streamline these processes. This could be achieved through automated technological solutions, such as pop-up alerts upon accessing the medical history, or by implementing clearer signalling and more direct, rapid clinical pathways to access the document.

Furthermore, while the promotion of advance directives is a shared responsibility, we believe it must be driven by healthcare leadership. Regional health administrations should provide more comprehensive information to the citizenry regarding the document, while hospital management could incorporate the consultation of advance directives as a standardized quality indicator within clinical protocols.

Finally, the high level of professional receptivity (88.3%) suggests that the primary barrier is not a lack of willingness, but rather a lack of empowerment and knowledge. We recommend leveraging this positive attitude by transforming advance directives from a 'legal document' into a routine therapeutic tool. It should function as an extension of informed consent—granting patients the opportunity to decide how they wish to be treated in scenarios where they lack autonomous decision-making capacity. Training should focus on Shared Decision-Making models, encouraging professionals to initiate these conversations during clinically stable periods, thus evolving advance directives into a dynamic roadmap for the therapeutic relationship rather than a static legal requirement.

It is important to examine how gaps in ethical-legal training directly affect AD implementation. Weak knowledge in these areas may lead to inconsistent or incorrect application, compromising care quality. We therefore propose targeted strategies: continuous-education modules focusing on the ethical and legal dimensions of ADs; practical workshops using simulation scenarios; and accessible point-of-care resources for rapid consultation.

Countering the prevailing paternalistic culture and strengthening collaborative relationships with patients is pivotal (Elbogen et al., 2006; Nicaise et al., 2015). In shared decision-making, both professionals and patients should have space to discuss the reasons behind treatment refusal, which may yield more coherent, informed decisions (Wilder et al., 2007). Identifying when and how to initiate these conversations about anticipatory decisions is also critical (Moraes et al., 2022).

The prevalence of these barriers, alongside inadequate training, hinders effective AD implementation in mental health. This underscores insufficient investment in continuous, specialized professional development for AD management. The result is a cycle in which uncertain or under-prepared professionals produce suboptimal, inconsistent applications of the ethical principle of autonomy. Strategies to reduce these barriers should be bidirectional: bolster professional education and development while clarifying institutional support and establishing coherent AD policies (Avila & Leeper, 2022).

Institutional policies should also be strengthened to promote respect for patients' autonomy and dignity, ensuring explicit support and guidance from healthcare organisations and government bodies.

Our study has limitations that may have influenced the results and should inform future research. First, the geographic concentration in a single hospital (Parc Sanitari Sant Joan de Déu) constrains generalisability to other clinical contexts, regions, or countries. Cultural, organisational, and policy differences may substantially shape professionals' perceptions and experiences. It is important to note that a potential non-response bias may be present in our study. Indeed, it is plausible that professionals with a greater interest in respecting patient autonomy, or those already familiar with advance directives, were more inclined to participate in the survey. In this sense, there may be an overestimation of positive attitudes and perceived competencies compared to the broader population of mental health professionals. Nevertheless, data anonymization through the REDCap platform was intended to mitigate this risk and encourage honest reporting regarding knowledge gaps.

Second, given the ethically sensitive nature of the topic, social desirability bias may have led participants to provide answers aligned with perceived professional norms.

Uncontrolled variables—such as the urgency and severity of clinical situations in which ADs might be implemented—also matter, as they can strongly influence clinical decisions and, consequently, professionals' perceptions of ADs. Heterogeneity in training, experience, and specialties among participants is another relevant factor that may have affected familiarity, competence, and confidence in implementing ADs. Due to the exploratory and descriptive nature of this study, statistical tests were not performed to analyze differences between professional roles or demographic subgroups, such as years of experience. However, considering the heterogeneity of the sample—which encompasses a wide range of mental health disciplines—future research should incorporate additional inferential analyses, such as chi-square or ANOVA. These investigations will be essential to determine whether specific professional categories or levels of clinical experience significantly impact knowledge and attitudes toward advance directives among patients with mental illness. Finally, the absence of patient and family perspectives precludes a holistic view of AD implementation and limits understanding of how advance decisions are perceived and experienced by those most affected. This omission is notable given evidence that patients can clearly articulate general preferences, perceived benefits, and the barriers and facilitators associated with planning decisions (Braun et al., 2023).

6. Conclusions

This study highlights a discernible gap between theory and clinical practice regarding ADs among mental-health professionals within the specific context of the Spanish healthcare system. Although the document and patient autonomy are acknowledged and respected at a theoretical level, practical implementation is hindered by multiple barriers, including limited experience, inadequate tools, and gaps in professional training.

By examining these discrepancies, we identified tangible constraints at both clinical and institutional levels. Despite generally positive attitudes toward the AD, pragmatic barriers—together with insufficient support and resources—impede its effective integration into routine practice.

We propose several recommendations to advance the human rights of people with mental disorders. First, targeted education: develop specific training programmes to strengthen understanding and the skills required for efficient AD application. Second, clear protocols: design and disseminate unambiguous institutional and policy guidelines to orient and streamline implementation. These recommendations should guide national and institutional mental health policies, as their integration could facilitate measurable improvements in clinical practice and help ensure greater respect for the human rights of people with mental illnesses. The implementation of such measures is a necessary step that may reinforce support systems for mental-health professionals and could contribute to a more coherent and effective integration of ADs in clinical settings.

It is important to note that although these findings are primarily applicable to the Spanish mental health framework, it must be acknowledged that results may vary in other international contexts characterized by different legal regulations or institutional cultures.

Declaration of generative AI in scientific writing

This manuscript used AI-assisted tools for language editing and translation from Spanish to English under author supervision. All content was reviewed for accuracy, coherence, and disciplinary style, and the authors take full responsibility for the final text.

Funding

This study received a €10,470 grant for research in emerging areas from the Vice-Rectorate for Research at the University of Barcelona (AS017668), awarded through a competitive call.

CRediT authorship contribution statement

Sergio Ramos-Pozón: Conceptualization, Investigation. **Anna Falcó-Pegueroles:** Conceptualization, Investigation. **Silvia Poveda-Moral:** Investigation. **Hilari Andrés-Mora:** Investigation. **Raquel Fabregat-Marcos:** Investigation. **Ramon Mir-Abellan:** Investigation. **Luisa Baladón-Higueras:** Investigation. **Begoña Roman:** Conceptualization. **Bernabé Robles:** Conceptualization. **Eva Garrido-Aguilar:** Investigation.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgement

The researchers would like to express their gratitude to all participants.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijlp.2026.102224.

References

Aguilar, J., Cabañero, M., Puerta, F., Ladios, M., Fernández, J., & Cabrero, J. (2018). Grado de conocimiento y actitudes de los profesionales sanitarios sobre el documento de voluntades anticipadas. *Gaceta Sanitaria, 32*(4), 339–345.

Álvarez, S., Argüelles, S., Álvarez, M., Fernández, T., Blanco, M., & Del Castillo, F. (2015). Conocimientos y actitud de las enfermeras de atención primaria sobre las voluntades anticipadas. *RqR Enfermería Comunitaria, 3*(1), 66–77.

Ameneiros, E., Carballada, C., & Garrido, J. (2013). Conocimientos y actitudes sobre las instrucciones previas de los médicos de atención primaria y especializada del área sanitaria de ferrol. *Revista de Calidad Asistencial, 28*(2), 109–116.

Amering, M., Denk, E., Griengl, L., Sibitz, I., & Stastny, P. (1999). Psychiatric wills of mental health professionals: A survey of opinions regarding advance directives in psychiatry. *Social Psychiatry and Psychiatric Epidemiology, 34*(1), 30–34. https://doi.org/10.1007/s001270050108

Avila, A., & Leeper, E. (2022). Assessment of barriers to effective use of psychiatric advance directives: Providers' knowledge and attitudes. *Psychological Services, 19*(2), 271–282.

Backlar, P., McFarland, H., Swanson, J., et al. (2001). Consumer, provider, and informal caregiver opinions on psychiatric advance directives. *Administration and Policy in Mental Health, 28*(6), 427–441.

Belden, C., Gilbert, A., Easter, M., Swartz, M., & Swanson, J. (2022). Appropriateness of psychiatric advance directives facilitated by peer support specialists and clinicians on assertive community treatment teams. *Journal of Mental Health, 31*(2), 239–245. https://doi.org/10.1080/09638237.2021.1952946

Bianchi, D. (2020). Advance directives: Addressing the obligations of support as part of the right of a person with disabilities to equal recognition before the law. *International Journal of Law and Psychiatry, 70*, Article 101561. https://doi.org/10.1016/j.ijlp.2020.101561

Braun, E., Gaillard, A., Vollmann, J., Gather, J., & Scholten, M. (2023). Mental health service users' perspectives on psychiatric advance directives: A systematic review. *Psychiatric Services, 74*(4), 381–392. https://doi.org/10.1176/appi.ps.202200003

Caraco, C., Smith, B., & Ward, B. (2023). Psychiatric advance directives: A call for humanization. *Psychiatric Services, 74*(4), 331. https://doi.org/10.1176/appi.ps.23074007

Chan, H. Y., Kwok, A. O., Yuen, K. K., Au, D. K., & Yuen, J. K. (2020). Association between training experience and readiness for advance care planning among healthcare professionals: A cross-sectional study. *BMC Medical Education, 20*, 451. https://doi.org/10.1186/s12909-020-02347-3

Contreras, E., Barón, F., Méndez, C., et al. (2017). Validación del cuestionario de conocimientos y actitudes de los profesionales sanitarios en el proceso de declaración de voluntades vitales anticipadas. *Atención Primaria, 49*(4), 233–239.

Contreras, E., Rivas, F., Castilla, J., et al. (2015). Conocimientos y actitudes de los profesionales sanitarios en el proceso de declaración de las voluntades vitales anticipadas. *Atención Primaria, 47*(8), 514–522.

Dalmau, A., Saura, A., Busquets, J. M., Bullich, I., & García, A. (2022). Advance directives and real-world end-of-life clinical practice: A case–control study. *BMJ Supportive & Palliative Care, 12*, e337–e344.

Easter, M., Swanson, J., Robertson, J., Moser, L., & Swartz, M. (2021). Impact of psychiatric advance directive facilitation on mental health consumers: Empowerment, treatment attitudes and the role of peer support specialists. *Journal of Mental Health, 30*(5), 585–593. https://doi.org/10.1080/09638237.2020.1714008

Elbogen, E., Swartz, M., Van Dorn, R., et al. (2006). Clinical decision making and views about psychiatric advance directives. *Psychiatric Services, 57*, 350–355.

Fajardo, M., Valverde, F., Jiménez, J., et al. (2015). Grado de conocimiento y actitudes de los profesionales ante el documento de voluntades anticipadas: Diferencias entre distintos profesionales y provincias de una misma autonomía. *Semergen, 41*(3), 139–148.

Gaillard, A., Braun, E., Vollmann, J., Gather, J., & Scholten, M. (2023). The content of psychiatric advance directives: A systematic review. *Psychiatric Services, 74*(1), 44–55. https://doi.org/10.1176/appi.ps.202200002

Gloeckler, S., Scholten, M., Weller, P., Keene, S., Pathare, S., Pillutla, R., Leticia, R., et al. (2025). An international comparison of psychiatric advance directive policy: Across eleven jurisdictions and alongside advance directive policy. *International Journal of Law and Psychiatry, 101*, Article 102098. https://doi.org/10.1016/j.ijlp.2025.102098

Glue, J., Potiki, J., O'Brien, A., et al. (2021). Help and hindrances to completion of psychiatric advance directives. *Psychiatric Services, 72*(2), 216–218.

Glue, J., Thom, K., O'Brien, A., Potiki, J., Casey, H., Dawson, J., & Glue, P. (2020). The content of mental health advance preference statements (MAPs): An assessment of completed advance directives in one New Zealand health board. *International Journal of Law and Psychiatry, 68*, Article 101537. https://doi.org/10.1016/j.ijlp.2019.101537

Glue, J., Thomb, K., O'Brien, T., et al. (2020). The content of mental health advance preference statements (MAPs): An assessment of completed advance directives in one New Zealand health board. *International Journal of Law and Psychiatry, 68*, Article 101537. https://doi.org/10.1016/j.ijlp.2019.10153

Granero, R., Frías, A., Barrio, I., et al. (2016). Dificultades de las enfermeras de atención primaria en los procesos de planificación anticipada de las decisiones: Un estudio cualitativo. *Atención Primaria, 48*(10), 649–656.

Herreros, B., Benito, M., Gella, P., et al. (2020). Why have advance directives failed in Spain? *BMC Medical Ethics, 21*(1), 113. https://doi.org/10.1186/s12910-020-00557-4

Hotzy, F., Cattapan, K., Orosz, A., Dietrich, B., Steinegger, B., Jaeger, M., et al. (2020). Psychiatric advance directives in Switzerland: Knowledge and attitudes in patients compared to professionals and usage in clinical practice. *International Journal of Law and Psychiatry, 68*, Article 101514. https://doi.org/10.1016/j.ijlp.2019.101514

Jami, A., Falcón, E., & Padrón, L. (2023). Factors that limit the planning of advance directives from the perspective of health professionals. *Revista Qualitas, 26*(26), 013–037. https://doi.org/10.55867/qual26.02

Jiménez, J., & Farouk, M. (2015). Conocimiento, actitud y planificación de la voluntad vital anticipada en el distrito sanitario guadalquivir de la provincia de córdoba. *Med Gen y Fam, 4*(4), 114–118.

Juliá, R., Cabañero, M., Zaragoza, M., et al. (2020). Knowledge and attitudes of Spanish mental health professionals towards advance healthcare directives. *Journal of Psychiatric and Mental Health Nursing, 27*, 699–708.

Juliá, R., García, S., Zaragoza, M., et al. (2019). Advance healthcare directives in mental health: A qualitative analysis from a Spanish healthcare professionals viewpoint. *Journal of Psychiatric and Mental Health Nursing, 26*, 223–232.

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

Lenagh, J., Dawson, J., Potiki, J., O'Brien, A., Thom, K., Casey, H., & Glue, P. (2023). Use of advance directives to promote supported decision-making in mental health care: Implications of international trends for reform in New Zealand. *The Australian and New Zealand Journal of Psychiatry, 57*(5), 636–641. https://doi.org/10.1177/00048674221079225

Ministry of Health. (2025). Declarants with an active advance instruction (advance directive) by autonomous community and age groups (january 2025). https://www.sanidad.gob.es/en/areas/profesionesSanitarias/rnip/home.htm.

Moraes, L., Rebello, M., Fernandes, W., Nunes, R., & Rego, F. (2022). Advance care planning: A practical guide. *Revista Bioética (Impresso), 30*(3). https://doi.org/10.1590/1983-80422022303546EN

Murray, H., & Wortzel, S. (2019). Psychiatric advance directives: Origins, benefits, challenges, and future directions. *Journal of Psychiatric Practice, 25*(4), 303–307.

Nicaise, P., Soto, V., Dubois, V., et al. (2015). Users' and health professionals' values in relation to a psychiatric intervention: The case of psychiatric advance directives. *Administration and Policy in Mental Health, 42*, 384–393.

O'Connell, M., & Stein, C. (2005). Psychiatric advance directives: Perspectives of community stakeholders. *Administration and Policy in Mental Health, 32*(3), 245–265.
Porcar, E., Peral, D., & Gisbert, M. (2021). El documento de voluntades anticipadas. comparativa de la legislación actual en el marco de la unión europea. *Revista Española de Medicina Legal, 47*, 66–73.
Poveda, S., De la Casa, P., Sánchez, P., Pomares, N., Vicente, M., & Falcó-Pegueroles, A. (2021). Association between knowledge and attitudes towards advance directives in emergency services. *BMC Medical Ethics, 22*(1), 1–15.
Poveda, S., Falcó-Pegueroles, A., Ballesteros, M., & Bosch, A. (2021). Barriers to advance care planning implementation in healthcare: An umbrella review with implications for evidence-based practice. *Worldviews on Evidence-Based Nursing, 18*(6), 485–494.
Poveda, S., Rodríguez, D., Codern, N., María, P., Sánchez, P., Pomares, N., Vicente, M., & Falcó-Pegueroles, A. (2020). Managing ethical aspects of advance directives in emergency care services. *Nursing Ethics, 28*(1), 91–105.
Redahan, R., Kelly, B., & Gergel, T. (2024). Advance healthcare directives and advance choice documents in psychiatry: New resources, new legislation, new opportunities. *International Journal of Law and Psychiatry, 97*, Article 102030. https://doi.org/10.1016/j.ijlp.2024.102030
Reilly, J., & Atkinson, J. (2010). The content of mental health advance directives: Advance statements in Scotland. *International Journal of Law and Psychiatry, 33*, 110–121.
Rouco, J., Tuñas, D., Iglesias, M., et al. (2015). Conocimientos y actitudes de los profesionales de enfermería de atención primaria sobre el documento de instrucciones previas (DIP). *Revista Iberoamericana de Enfermería Comunitaria, 8*(2).
Schiffman, I., & Werner, P. (2017). Knowledge regarding advance care planning: A systematic review. *Archives of Gerontology and Geriatrics, 73*, 133–142.
Scholten, M., Gieselmann, A., Gather, J., & Vollmann, J. (2019). Psychiatric advance directives under the convention on the rights of persons with disabilities: Why advance instructions should be able to override current preferences. *Frontiers in Psychiatry, 10*, Article 631. https://doi.org/10.3389/fpsyt.2019.00631
Shields, L., Pathare, S., van der Ham, S., & Bunder, J. (2014). A review of barriers to using psychiatric advance directives in clinical practice. *Administration and Policy in Mental Health, 41*, 753–766. https://doi.org/10.1007/s10488-013-0523-3
Simón, P., Tamayo, M., Vázquez, A., et al. (2008). Conocimientos y actitudes de los médicos en dos áreas sanitarias sobre las voluntades vitales anticipadas. *Atención Primaria, 40*(2), 61–68.
Srebnik, D., & Brodoff, L. (2003). Implementing psychiatric advance directives: Service provider issues and answers. *Journal of Behavioral Health Services & Research, 30*(3), 253–268.
Stephenson, L., Gieselmann, A., Gerge, T., Owen, G., Gather, J., & Scholten, M. (2023). Self-binding directives in psychiatric practice: A systematic review of reasons. *The Lancet Psychiatry, 10*(11), 887–895. https://doi.org/10.1016/S2215-0366(23)00221-3
Swanson, J., McCrary, V., Swartz, M., Van Dorn, R., & Elbogen, E. (2007). Overriding psychiatric advance directives: Factors associated with psychiatrists' decisions to preempt patients' advance refusal of hospitalization and medication. *Law and Human Behavior, 31*(1), 77–90. https://doi.org/10.1007/s10979-006-9032-1
Swartz, M., Swanson, J., Easter, M., et al. (2021). Implementing psychiatric advance directives: The transmitter and receiver problem and the neglected right to be deemed incapable. *Psychiatric Services, 72*(2), 219–221.
Tekkalaki, B., Patil, V., Patil, N., et al. (2018). How do our patients respond to the concept of psychiatric advance directives? An exploratory study from India. *Indian Journal of Psychological Medicine, 40*(4), 305–309.
Thom, K., Johan, A., & José, J. (2015). Service user and clinical perspectives of psychiatric advance directives in New Zealand. *International Journal of Mental Health Nursing, 24*(6), 554–560.
Tinland, A., Loubière, S., Mougeot, F., Jouet, E., Pontier, M., Baumstarck, K., Loundou, A., Franck, N., Lançon, C., Auquier, P., & DAiP Group. (2022). Effect of psychiatric advance directives facilitated by peer workers on compulsory admission among people with mental illness: A randomized clinical trial. *JAMA Psychiatry, 79*(8), 752–759. https://doi.org/10.1001/jamapsychiatry.2022.1627
Van Dorn, R., Swartz, M., Elbogen, E., Swanson, J., Kim, M., Ferron, J., et al. (2006). Clinicians' attitudes regarding barriers to the implementation of psychiatric advance directives. *Administration and Policy in Mental Health, 33*(4).
Vázquez, M., Tizón, E., Martínez, A., et al. (2020). ¿qué conocen las enfermeras de galicia sobre las voluntades anticipadas? *Enfermería Clínica, 30*(1), 16–22.
Wilder, C. H., Swartz, M. S., Elbogen, E. B., et al. (2007). Effect of patients' reasons for refusing treatment on implementing psychiatric advance directives. *Psychiatric Services, 58*, 1348–1350.