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vii. Ethics details

The Ethics Committee at the University of Alicante authorized the study (request No. UA-2017-09-14). Consent was requested from the study participants and the confidentiality of the data obtained was guaranteed. Once the respondents presented their answers, the computer program used to collect the data automatically thanked them for their participation.

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All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors, and that all authors agree with the manuscript. RJS and MJCM conceived the study and designed the trial. RJS supervised the conduct of the trial and data collection. RJS and SGS undertook recruitment of participating centers and professionals and managed the data, including quality control. RJS and MJCM provided statistical advice on study design and analyzed the data; MFZM chaired the data oversight committee. RJS drafted the manuscript, and all authors contributed substantially to its revision. RJS and MJCM take responsibility for the paper as a whole.

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KNOWLEDGE AND ATTITUDES OF SPANISH MENTAL HEALTH PROFESSIONALS TOWARDS ADVANCE HEALTHCARE DIRECTIVES

ABSTRACT

Introduction: Advance healthcare directives (AHDs) in mental health offer important information regarding service users' preferences. However, whether AHDs are truly understood by providers is questionable. **Aim:** To survey the knowledge and attitudes of mental health professionals towards AHDs and examine any associations with socio-demographic and occupational variables. **Method:** We cross-sectionally surveyed the knowledge and attitudes of 113 mental health professionals by using two validated questionnaires. **Results:** Participants showed very positive attitudes and high levels of knowledge about the conceptual definition and application of AHDs in clinical practice but their knowledge of the legalities, procedure and registration of AHDs was poor. Working in a community, having a career specializing in mental health, or having personally signed an AHD was associated with enhanced knowledge about them. Moreover, female sex or employment as an auxiliary nursing-care technician was associated with stronger positive attitudes. **Discussion:** Legal and structural changes will be needed to implement AHDs in Spain and to promote competence among healthcare providers in order to include AHDs in everyday practice. **Implications for practice:** The Spanish mental healthcare system requires legal and structural changes and must improve healthcare providers' competence in AHDs before they are implemented. **Relevance statement:** Despite the United Nations requirements, and work to raise awareness by advocacy groups, the implementation of AHDs in mental health is not yet a reality in Spain. Over the last few years, legislature recognizing users' right to participate in decision-making processes has slowly increased. However, healthcare professionals tend not to involve users in health education or decisions relevant to

the patient's own health. Thus, mental healthcare professionals should receive further training to reinforce this model in preparation for them to implement AHDs in everyday practice.

Key words: advance directive, attitudes, knowledge, mental health, professional

Accessible Summary

What is known on the subject?

- AHDs in mental health are fundamental tools in advance care planning processes. It is an important method for involving mental healthcare users in clinical decisions and in providing effective healthcare based around user preferences.
- AHDs can be applied in situations in which the person may forfeit their legal capacity, according to the Convention on the Rights of Persons with Disabilities.
- However, the use of AHDs as described above is not yet a reality in Spain.

What the paper adds to existing knowledge.

- The present study surveys the knowledge and attitudes of mental healthcare providers towards AHDs in clinical practice.
- Although providers had a moderate–low level of knowledge about AHDs, they presented positive attitudes towards them.

What are the implications for practice?

- The use of AHDs in mental healthcare practice poses challenges to the Spanish mental healthcare system. Acquiring up-to-date data on the knowledge and attitudes of providers towards AHDs allows organizations to address aspects of their service that require reinforcement. This data could also be used by other countries just starting to use AHDs, as an initial step towards supporting the implementation of a multistage intervention process.
- More in-depth training for providers would help improve their competence to implement or honor the statements set out in AHDs, the related legal and ethical issues, and liability issues related to their implementation.
- The Spanish mental healthcare system requires structural changes so that providers can embrace new ways of relating to users and to organize partnerships and a continuity of care centered on user preferences.

INTRODUCTION

The approval of the United Nations Convention on the Rights of Persons with Disabilities (CRPD; UN, 2006), was a huge milestone in the history of the rights of people with mental illness. Since its entry into force on 3 May 2008, there has been notable progress in the promotion of collective rights and the development of legislation, strategies, policies, and programs for equality, inclusion, and the empowerment of the individuals covered by the CRPD. This is thanks to, among other reasons, the enactment of the right to autonomy, information, and participation in clinical decision-making (Hamann et al., 2011).

Since then, several international reports (UN, 2017; WHO, 2012) have identified situations of human rights violations associated with institutional policies and inadequate professional practices, the failure to recognize the legal status of individuals, respect their privacy, freedom of expression and opinion, provide protection against degrading treatment, or access to information and health care (Suess Schwend et al., 2016). Consequently, the Council of Europe recommended that member states change some of their bioethics policies and mental health legislation (European Parliament, 2017). This implied the inclusion of users of mental health services in decision-making processes and the regulation of advance healthcare directives (AHDs) in line with Article 12 of the CRPD (Slade, 2017). Member states were also advised to align their legislation accordingly and to provide appropriate measures for supported decision-making and AHDs (Gieselmann et al., 2018).

The literature describes different types of AHDs in mental health (Henderson et al. 2008) depending on the range of stakeholders involved in their completion. The ‘classic AHD’ was meant to be individually produced by the user. However, to increase their rate of use, some measures were introduced to help users state their preferences, resulting in a new type of AHD called a ‘facilitated AHD’ (f-AHDs; Easter et al., 2017). These actions included the provision of information sessions, structured booklets to fill in, the use of hypothetical scenarios, and a computer-assisted directive. A third type of plan is the ‘joint crisis plan’, which involves a negotiated completion process carried out by users and their relatives alongside mental health providers.

Joint crisis plans are used within the framework of Advance Care Planning and aims to improve the therapeutic working alliance (Henderson et al., 2008) and the rate AHD use (Nicaise, Lorant and Dubois, 2013). This process leverages caregivers’ knowledge and understanding of their patients to support users, enabling them to document their personal values, life goals, and preferences for their future healthcare. These AHDs are used should the user be unable to make decisions for themselves because of a temporary loss of their

capacities (as functionally interpreted) secondary to alterations of consciousness or serious illnesses (Sudore et al., 2017). The open and flexible content of the document allows users to express their wills and preferences about the treatment decisions, crisis interventions, and clinical procedures that may become necessary during their healthcare and that directly affect them (Kelly, 2017). They also usually allow users to identify the legal representatives who would act on their behalf should their own legal capacity come into question, and to specify who would be notified to administer their finances or care for their dependents or pets, etc. (Srebnik et al., 2005).

A systematic Cochrane review of the use of AHD in mental health found insufficient evidence to identify any specific findings regarding the role of AHDs in final patient outcomes, such as the number of psychiatric admissions, bed days, compliance with treatments, self-harm, or violence (Campbell & Kisely, 2009). However, AHDs seem to be promising recovery tools whose benefits included reduced crisis-symptom severity and coercive interventions, improved medication adherence and greater treatment satisfaction, earlier recovery, and improved therapeutic relationships between users, relatives, and providers (Tekkalaki et al., 2018; Suess Schwend et al., 2016). Moreover, from the perspective of service management, these outcomes were clinically useful and cost-effective (Easter et al., 2017).

However, the realist systematic review by Nicaise et al. (2013) pointed out numerous clinical and operational barriers to the use of AHDs in mental healthcare services. These included reticences on the part of many providers because of a fear that AHDs could be used to refuse all treatments and those users may be insufficiently aware of the possible consequences of their refusals. Other barriers to the use of AHDs included some providers or service users inability or insufficient knowledge to implement or honor the statements in the AHDs, legal liabilities and ethical issues relating to implementing or overriding them, and the capacity of the care system to organize partnerships and continuity of care around users' preferences (Nicaise et al., 2013; Swanson et al. 2006).

Although the recent ideological transition has favored the recognition of patients' rights as autonomous moral agents, moving from a paternalistic model to informed user-choice models, controversy persists about the capacity of mental health users to independently make decisions, especially regarding the need for the certification of this deficit (Duffy & Kelly, 2019; National Gold Standards Framework Center, 2019; Sudore et al. 2017). This would mean that, like the context of somatic care, involuntary psychiatric-care treatments could be implemented when necessary (Sjöstrand et al., 2015). Laws on

involuntary psychiatric treatment focus on the presence of serious mental illness, a need for treatment, or individuals posing a danger to themselves or others, but not on the patient's capacity to make autonomous decisions (Sjöstrand et al., 2015).

Rationale

Despite the United Nations requirements and efforts to raise awareness by advocacy groups, the implementation of AHDs in mental health settings lags far behind user interest (Easter et al., 2017). Recent changes in mental health legislation in different parts of the world (India, Australia, and USA) have triggered an interest in AHD in mental healthcare and a number of articles have been published describing implementation challenges and early results from practical experience evaluations (Jankovic, et al., 2019). Over the last few years, legislature recognizing patients' right to participate in decision-making processes within the Spanish healthcare setting has slowly increased. Examples are Law 41/2002, of November 14, regulating patient autonomy and rights, and the obligations of information and clinical documentation (for instance, the obligation to inform patients and their right to clinical documentation); Royal Decree 124/2007, of February 2, regulating the National Registry of Advance Directives and corresponding automated personal data files; and Law 26/2011, of August 1, which legislates normative adaptations to the International CRPD.

Unlike the availability of end-of-life care AHD registries, no generic or specific models for AHDs in the context of mental healthcare have yet been legally established in any branches of the Spanish mental health system. Low rates of use (4–11%) are reported for all the available AHD legal documents in the United States (Swanson et al., 2006) and some European countries, including Germany (Giesermann et al., 2018) and England and Wales (Owen et al., 2019). Nonetheless, the completions of AHDs within the Spanish mental health services are currently almost non-existent. Parallel to the development of specific policies, health providers must become more familiar and involved in the implementation of AHDs in order to increase their use. The endorsement of AHDs in times of crisis would be higher if health providers were aware of the legal parameters of the instructions provided within them (Thom et al., 2015) in the context of a therapeutic-alliance framework (Nicaise et al., 2013).

Some theoretical (Suess Schwend, 2016) and empirical research (Villagrán, Lara & González-Saiz, 2014), as well as a support guide for professionals and users of mental health services (Escuela Andaluza de Salud Pública, 2015) is available in relation to the Comprehensive Mental Health Plan of the *Junta de Andalucía*, but we found no evidence for its implementation. In addition, previous research in primary, specialist, and palliative mental healthcare fields at the national-level showed that providers were unaware of what an AHD

entails or how to complete one (Aguilar-Sánchez et al., 2018; Ameneiros et al., 2013; Champer Blasco et al., 2010; Fajardo Contreras et al., 2015; Nebot, Ortega et al., 2010; Toro Flores et al. 2013). Thus, considering the international relevance and use of AHDs in clinical practice, it would be useful to collect information about mental health providers' general knowledge of AHDs and their attitudes towards them before implementing a multistage intervention process in the Spanish context.

Aims and objectives

To survey the knowledge and attitudes of mental health professionals towards AHDs and, examine any associations between these variables and sociodemographic and occupational variables.

METHODS

Study sample

This cross-sectional descriptive study was conducted between May and December 2018 using a convenience sampling method. The study population comprised physicians, nurses, auxiliary nursing-care technicians, psychologists, and social workers who performed their functions in psychiatric inpatient units (PIUs), adult or pediatric community mental health (CMHs) units, or recovery, rehabilitation, or social-inclusion units (RRSIUs) comprising addictive behavior units, day centers, and social and labor reintegration centers. Mental health professionals practicing in the province of Alicante (Spain) during the study period and with at least 1 year of experience and who voluntarily participated were included.

Variables and instruments

1) Sociodemographic and occupational variables

We recorded sociodemographic data (age and sex), the participants' job characteristics as their length of service (years of experience), workplace (PIUs, CMHs, RRSIUs), occupational category (nurse, auxiliary nursing-care technician, physician, psychologist, or social worker), and whether their career specialized in mental health (yes/no). In addition, data about the cohort's previous experience in the management of AHDs (yes/no) and their interest in receiving training related to AHDs were collected (yes/no).

2) Advanced healthcare directive questionnaire

Considering the advance care planning process is not yet a practical or legal reality for mental healthcare service users, we had to use generic questionnaires. These had previously been validated for use in the Spanish health system to study similar sample cohorts and

showed good validity, feasibility, and comprehensibility factors (Aguilar-Sánchez et al., 2018).

The *Knowledge Questionnaire* was originally developed by Champer et al. (2010) and contains 18 items grouped into five blocks: (I) conceptual definition (2 items); (II) general legal aspects (5 items); (III) procedure and registration (4 items); (IV) contents (4 items), and (V) application of AHDs in clinical practice (3 items). Each item has three response options: 'yes', 'no', or 'do not know'. Because item 1 referred to end-of-life AHDs, we adapted it, with the scale author's permission, thus: "*Advance directives are instructions that should be followed in situations where the patient's psychological capacity becomes questionable and this document must be taken into account when the person cannot express their own will*".

To determine the interviewee's level of knowledge about AHDs, 1 point was assigned to each correct answer and 0 points were given when an incorrect response or no answer was provided. The original authors defined a minimum correct overall response pattern comprising 12 items: two from the conceptual definition block, four from the block on general legal aspects, three from the procedure and registration block, and three from the AHD content block. We did not include any items on the application of AHDs in clinical practice. The mean number of correct answers was calculated for each block and we transformed the scores to a 0–100 scale.

The *Knowledge and Attitudes Questionnaire* was originally developed by Simón-Lorda et al. (2008) and contains 12 items. The first item examines professionals' self-perception of knowledge; the second and third used categorical scales to assess their knowledge of AHDs; and the remaining 9 items assessed attitudes towards AHDs. Responses were offered on a 10-point Likert scale, where 0 was the worst score and 10 was the best; the internal consistency of the scale (Cronbach's alpha) was 0.90.

Data collection

Potential participants were identified via key informants (nursing supervisors) and were contacted by an e-mail letter which briefly presented the study, its voluntary and anonymous nature, and provided a link to the online informed consent form and the self-administered internet-hosted questionnaire. No incentive was offered to take part in the study. To encourage a high response rate, we used a standardized mailing procedure to e-mail a reminder 1, 2, and 3 weeks after the questionnaire had first been sent, each containing a link to the questionnaire and a reminder about the importance of their participation.

According to previous research, we required a minimum sample size of 100 (García-García et al., 2013). There were no missing data because every item included was mandatory.

In practice, online data collection presented several advantages: it was a simple, fast, and low-cost system both for researchers and participants (Cantrell & Lupinacci, 2007). The questionnaire could be answered at any time and place, fostering a greater sense of freedom among the participants, and therefore likely decreasing social desirability and data collection bias and increasing data accuracy (Cantrell & Lupinacci, 2007; Heiervang & Goodman, 2011).

Data analysis

A descriptive analysis of the response frequency was performed for each of the categorical items and the mean and standard deviation ($\bar{x} \pm SD$) were calculated for the continuous variables. Pearson linear correlation coefficients (r) were calculated to assess the association between participant age and years of experience and both the global scale scores as well as those for the items on the self-perception of knowledge. For independent samples, Student t -tests were used to contrast the means according to sex for the correct minimum correct response pattern, self-perception of knowledge, and attitudes towards AHDs. To check the validity of the sum of the items about attitudes, we carried out a principal components analysis and computed its scree plot. We also calculated the internal consistency of the summation as the Cronbach alpha statistic; analysis of variance (ANOVA) statistical calculations were used to contrast the means from more than two groups. The results from all these tests were considered statistically significant when $p < 0.05$; all the analyses were performed using the IBM SPSS statistics package, version 22.0 (IBM Corp., Armonk, NY).

Ethical considerations

The Ethics Committee at the University of Alicante authorized the study (request No. UA-2017-09-14). Signed informed consent to participation was required from the study participants before the study commenced. Once the respondents had presented all their answers, the computer program used to collect the data automatically thanked them for their participation. The anonymity and confidentiality of the participants was maintained through the protected database hosted on the internet which stored the information by assigning an identification code to each participant. Only the principal investigator had access to this process.

RESULTS

Description of the sample

A total of 113 professionals participated in this study (table 1) and were aged between 23 and 64 years (46.9 ± 11.0); 70.8% ($n = 80$) were female. Most of the participants were nurses (42.5%) and auxiliary nursing-care technicians (32.7%) and most (60.2%) had a career

specializing in mental health. The mean experience in mental health fields for the cohort was 14.7 ± 10.4 years, with a wide range of 1–41 years. PIUs (43.4%) were the most represented clinical service, followed by CMHs (26.5%). Only 3.5% of participants had written their own AHD, and only 1.8% indicated that they were not interested in participating in training activities about AHDs.

Knowledge and attitudes

Table 2 shows the knowledge level scores; the highest mean score was obtained for the block relating to the conceptual definition of AHDs (85.84 points), followed by the block about the application of AHDs in clinical practice (63.42 points). The lowest mean scores were related to the content of AHDs (34.73 points) and AHD procedure and registration (36.50 points). The mean of the ‘overall scores’ and the ‘minimum correct response pattern’ scores were practically identical, indicating that participants’ knowledge about AHDs was moderate–low.

Table 3 shows the knowledge and attitudes questionnaire scores. Participants had a moderate–low self-perception of their knowledge about AHDs (4.49 ± 2.17 points); 65.5% were aware that AHDs were regulated by law, but only 29.2% ($n = 33$) claimed to have familiarized themselves with this legislation. The mean score for item 11, (participants’ desire to respect users’ AHDs) was 9.47 points ($SD = 0.88$) while for item 12 (the probability of the participant completing their own AHD in the following year) it was 7.75 points ($SD = 2.52$). The ‘attitude scale’ score, was 80.53 points ($SD = 10.29$, range = 0–90) for the whole sample.

Professionals working in CMHs ($F = 3.50$; $p = 0.034$) had significantly higher scores on this scale, especially for the legal ($F = 6.85$; $p = 0.020$) and practical application blocks ($F = 3.55$; $p = 0.032$), compared to the remaining participants. Professionals whose career was specialized in mental health also had significantly higher scores ($t = 5.76$; $p = 0.018$), especially in the practical application block ($F = 4.54$; $p = 0.035$). In addition, professionals who had read ($t = 5.79$; $p = 0.018$) or had their own AHD ($t = 5.70$; $p = 0.019$) scored higher in the conceptual definition block. The attitude scale score was low for the knowledge questionnaire ($r = 0.20$, $p = 0.033$) and the minimum correct knowledge response pattern ($r = 0.23$, $p = 0.015$). Age and the participants’ years of experience were not significantly related to the scores of the scales used in this study. In general, women ($t = 12.72$; $p = 0.001$) and auxiliary nursing-care technicians ($F = 2.64$; $p = 0.027$) had significantly higher scores on the attitudes scale.

DISCUSSION

This report represents the first study carried out in Spain to analyze healthcare providers' perspectives on AHDs in mental health. Although large initiatives have started emerging in recent years in Spain (Suess Schwend et al., 2016), unlike the end-of-life AHD registry, no generic or specific models for AHDs in the field of mental healthcare have yet been legally established nationwide in Spain. Acquiring current data on the knowledge and attitudes of providers towards AHDs allows organizations to focus on the factors that require reinforcement. This data could also be used by other countries in similar situations as a first step towards supporting the implementation of a multistage intervention process.

In line with the results from Aguilar-Sánchez et al. (2018) and Champer et al. (2010), the participants in this study usually had both a moderate–low self-perception and objective knowledge of AHDs, especially aspects related to their legality, content, registration, and related procedures. Our results also indicated that having a career specialty in mental health and being familiar with AHD documentation or having personally completed one were associated with better knowledge of them because of higher participant awareness. Thus, we recommend that healthcare providers' knowledge of AHDs be improved via educational strategies designed to teach them how to appropriately inform, refer, write, complete, and implement these directives. This would allow these professionals to encourage the participation of all the stakeholders involved in each patient's therapeutic process (Slade, 2017).

In our opinion, the Spanish Ministry of Education should lead in the development of healthcare provider training curricula. Although the effects of implementing AHDs in fields related to mental healthcare would only become visible in the long-term, they are worth put into effect because they protect the rights of users (Suess Schwend et al., 2016; Tekkalaki et al., 2018) and are beneficial as a recovery tool. The Spanish Ministry of Health, along with Professional Nursing Councils and other Health Societies, should also promote legal and structural changes and raise awareness of the benefits of AHDs in terms of improved user autonomy, therapeutic alliances, and healthcare provision continuity. This would allow these healthcare providers to embrace new ways of appropriately relating to mental health users in routine practice (Jankovic, et al., 2019; Nicaise et al., 2013).

Despite the fear reported by several authors of AHDs as a tool for patient proscription or treatment rejection (Nicaise et al., 2013), our participants had positive attitudes towards AHDs and respected user autonomy and dignity. It is important to note that the work studying the updates in advance statements in adult mental healthcare done by Jankovic et al. (2019) revealed that less than half of users refused a particular treatment, and the majority of refusals

concerned specific medications where alternatives could be offered. These positive attitudes may reflect the transition to a user- and family-oriented care model in mental health fields (Slade, 2017). This is secondary to the legal obligation to implement the principles of the CRPD, legislative and strategic developments related to the rights of patients, and remodeling of the provider–user relationship by the introduction of advance care planning based on evidence disseminated in the literature and at scientific conferences (Sjöstrand et al. 2015; Süss Schwend et al., 2016).

Nevertheless, given that no model for AHDs has yet been legally established in the Spanish mental healthcare context, the relevance of a positive attitude towards an unknown intervention remains unclear. According to Ajzen's theory of planned behavior attitudes, a strong positive attitude is predictive of a final behavior mediated by an intention to implement (Orbell, Hodgkins, & Sheeran, 1997). Furthermore, there is some evidence regarding barriers to the implementation of intention behaviors (Nicaise et al., 2013). Therefore, many of the barriers to the use of an intervention process could likely be overcome by making clinical and operational changes to facilitate their implementation by providers. This would mean specifying the moment and care setting in which AHDs should be proposed to users, the process for their completion, and especially, the ways in which AHD documents are registered and disseminated, the conditions of their access, and steps that should be taken to honor them.

Previous studies (Juliá-Sanchis et al., 2019) showed that mental healthcare providers identify community mental health settings as the ideal service for supporting users in the process of completing an AHD because users are extensively followed-up and so their AHD can be recorded in their clinical notes. Thomas et al., (2018) also found that users preferred receiving crisis services in community settings because these healthcare providers know the users and can therefore establish valuable therapeutic alliances with them, allowing them to record and heed the shared knowledge of the user's medication preferences.

The classic AHD is challenging to complete without assistance and generates feelings of uncertainty about decision-making (Easter et al., 2017). Thus, from a service management perspective (the access, registration, and dissemination of AHD documents) the inclusion of agents with different therapeutic roles such as peer support workers (Cleary et al. 2018), in interdisciplinary teams might be a productive strategy (Gieselmann et al., 2018). Nonetheless, in our opinion, mental health nurses would be the best therapeutic agents to lead education about AHDs, either as a joint crisis plan or an f-AHD. This is because they could help guarantee user continuity of care (Hinderer & Lee, 2014) and can take responsibility for the

ethical and professional care of users (Wilson et al., 2018). Among other activities, this form of advance care planning would combine educational sessions and motivational interviewing with all the stakeholders involved (Jankovic et al., 2019).

To achieve the above, the workload in community mental healthcare settings would have to be assessed to ascertain if more mental health nurses would be required. The relationship of the number of mental health nurses to users quality of care, the mental health nurses quality of life, as well as the cost–benefits would also have to be measured (Sousa & Seabra, 2018). In conclusion, extra financial investment would be required to increase the number of nurses in mental healthcare facilities. These nurses would increase advocacy for AHDs and in turn, help to ensure patient safety and quality of care (Juliá-Sanchis, 2019; Sousa & Seabra, 2018).

Limitations

The most important limitation of this study was that it only considered the views of mental healthcare providers; we plan to study the perspectives of the users of these services in future research. In addition, the cross-sectional design of this study prevented us from examining any potential causal relationships between the variables we measured. Strong biases in social desirability and global attitudes may have also been present in our results because it is likely that more individuals with negative or neutral attitudes towards AHDs declined to participate in it. Furthermore, our data reflect the experience of providers from the province of Alicante (Spain) but cannot be extrapolated to other areas with different organization systems or geodemographic characteristics. Thus, future research should be designed to systematically measure attitudes towards AHDs among a wider variety of mental healthcare providers and in different cultural and organizational settings.

Of note, it was likely that the generic items included in the questionnaires we used to assess knowledge about AHDs did not adequately survey the care directives used in mental healthcare provision. This is because the increase in generic legislature recognizing users' right to participate in decision-making processes within the Spanish healthcare system was not accompanied by specific legislature within the mental healthcare context. Thus, these surveys did not assess the four basic mental health functions: prescription, proscription, surrogate decision-maker designation, and irrevocability during a crisis (Nicaise et al., 2013). This could have impacted our results because several barriers to the use of AHDs in mental healthcare are related to specific aspects of this field and the different documentation and procedures this context requires. Therefore, future studies must focus on finding, adapting to

Spanish, and validating a suitable mental health tool or developing a new, specific one for these purposes.

Conclusions

Even though mental health professionals' knowledge of the legal aspects, content, procedure, and registration of AHDs was moderate–low, their general attitudes towards AHDs were very positive. Working at a CMH, having a career specialty in mental health, being familiar with AHD documentation, or having personally signed an AHD was associated with enhanced knowledge about AHDs. Women and auxiliary nursing-care technicians more strongly approved of AHDs. Any future initiative to promote AHDs in our context would need to consider these results in order to support the implementation of a multistage intervention process.

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Table 1. Sociodemographic characteristics and occupational status (*N* = 113)

	<i>n</i> (%)
Age ($\bar{x} \pm SD$)	46.9 $\pm$ 11.0
Experience ($\bar{x} \pm SD$)	14.7 $\pm$ 10.4
Sex	
Female	80 (70.8)
Male	33 (29.2)
Workplace	
Psychiatric hospitalization unit	49 (43.4)
Recovery, rehabilitation, and social-inclusion unit	34 (30.1)
Mental health unit	30 (26.5)
Occupational category	
Nurse	48 (42.5)
Auxiliary nursing-care technician	37 (32.7)
Physician	14 (12.4)
Psychologist	11 (9.7)
Social worker	3 (2.7)
Mental health specialty	
Yes	68 (60.2)
No	45 (39.8)
Has signed their own AHD	
Yes	4 (3.5)
No	109 (96.5)
Would participate in AHD training activities	
Yes	111 (98.2)
No	2 (1.8)

AHD: advance healthcare directive

Table 2. Scores for the level of knowledge ($n = 113$)

Block and items	Mean (<i>SD</i>)	Transformed score	Success rate n (%)
Conceptual definition	1.72 (0.59)	85.84	
1. Advance directives are instructions to follow [...] ^a			101 (89.4)
2. AHDs are based on the patient's right to autonomy ^a			93 (82.3)
Legal aspects of AHDs	2.22 (1.34)	44.42	
4. The patient's family must agree with the content of the AHD [...] ^a			101 (89.4)
7. AHDs are directed to the physician in charge of the patient's care ^a			62 (54.9)
10. AHDs are regulated by law ^a			82 (72.6)
14. AHDs can include descriptions of situations in which their application may be temporarily suspended ^a			53 (46.9)
15. The attending physician is required by law to follow the AHD ^a			71 (62.8)
Procedure and registration	1.46 (1.19)	36.50	
5. AHDs can only be formalized by a notary ^a			86 (76.1)
8. AHDs have a special format designed by the health department ^a			75 (66.4)
11. Anyone can write their own AHD			56 (49.6)
13. AHDs are only valid if you are registered in the health department's registry ^a			69 (61.1)
AHD content	1.39 (1.06)	34.73	
3. A representative must be appointed within AHDs ^a			
6. AHDs can include aspects contrary to current legislation ^a			
12. AHDs must include instructions on organ donation ^a			
16. AHDs are currently accepted that contain aspects contrary to current legislation			
Application of AHDs in practice	1.90 (1.07)	63.42	
9. The physician in charge has a moral obligation to follow AHDs			70 (61.9)

17. If the physician in charge knows the patient's wishes, they have a moral duty to honor them [...]										41 (36.3)
18. If the physician in charge does not want to follow the patient's wishes, they have a moral duty to transfer the patient [...]										73 (64.6)
Total scale (18 items)							8.69 (3.77)	48.27		
Minimum correct response pattern (12 items)							5.85 (2.67)	48.75		
AHD:	advance	healthcare	directive;	SD:	standard	deviation;	^a Items	comprising	the	minimum correct response pattern.

1 **Table 3. Scores for the knowledge and attitudes questionnaire (N = 113)**

Item	Mean	SD
Knowledge		
1. Self-perception of knowledge	4.49	2.17
2. Advance healthcare directives are regulated by law, <i>n</i> (%)		
Yes	74 (65.5)	
No	7 (6.2)	
Do not know/no answer	32 (28.3)	
3. Have read the law related to AHDs, <i>n</i> (%)		
Yes	33 (29.2)	
No	80 (70.8)	
Attitudes	80.05	10.73
4. It is useful to plan and write down one's wishes	9.12	1.26
5. AHDs are useful documents for professionals	9.04	1.43
6. AHDs are useful tools for relatives	9.03	1.58
7. The legal representative facilitates professional decision-making	9.09	1.42
8. I would recommend my patients complete an AHD	8.63	1.63
9. I would like my family members to complete an AHD	9.05	1.44
10. I would complete my own AHD	8.88	1.72
11. I would respect a patient's AHD	9.47	0.88
12. I am likely to complete my own AHD in the following year	7.75	2.52

2 AHD: advance healthcare directive document; *SD*: standard deviation