Resource Document

Psychiatric Advance Directives*

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Introduction

Advance directives were developed in the context of end of life care and are generally associated with medical and surgical decision-making for permanently incapacitated patients. Within psychiatry, interest in advance directives has been expressed as a means of facilitating the treatment of individuals afflicted with serious mental illnesses (Appelbaum, 1979). These disorders are typified by recurrent episodes of severe, cognition-impairing symptomatology that often result in decisional incapacity. Psychiatric advance directives (PADs) hold the promise of allowing individuals with mental illness, during a time of stability, to record treatment preferences that will presumptively guide the direction of care during incapacitating periods of illness.

To date, this promise has been largely unrealized. Available evidence indicates that relatively few psychiatric patients—ranging from 4-13% in public sector settings—report having executed a PAD (Swanson, Swartz, Ferron et al, 2006). In one study of patients with severe mental illness and believed to be at risk for future incapacity, less than 1% had a PAD (Swanson, Swartz, Elbogen et al, 2006). However in light of the attention that PADs have received in recent years, it is likely that an increasing number of patients will call on their psychiatrists to explain PADs and ask for their psychiatrists' assistance in formulating advance directives. Studies indicate that the majority of psychiatric patients, between 53% and 77%, report that they want a PAD, and many want their psychiatrists' assistance (Swanson, Swartz, Ferron 2006; Srebnik et al 2003). A recent study found that when provided with assistance, more than 60% of psychiatric patients completed PADs (Swanson, Swartz, Elbogen et al, 2006).

In recent years, fueled by grass roots interest in PADs, there has been a surge of activity in state legislatures. At the present time, there are 25 states that have adopted laws specifically authorizing PADs and defining their operation (National Resource Center, 2009). (In the remaining states, individuals may use general statute regarding medical advance directives to address psychiatric care, although some states impose limitations on scope). Information about PADs, including necessary forms, has become widely available online, supported by numerous groups including the National Resource Center for Psychiatric Advance Directives, the Bazelon Center for Mental Health Law, the Duke University Program on Psychiatric Advance Directives, the National Alliance on Mentally Illness, Mental Health America, and other advocacy groups.

With the rising tide of interest, it is likely that psychiatrists will be asked by patients to answer questions about PADs and to assist in formulating directives. Over time, psychiatrists are likely to find PADs becoming a more routine part of their clinical practices. This resource document will provide information about advance directives, their potential in facilitating the treatment of psychiatric patients, recent relevant research findings, and potential problems that may arise.

What are Advance Directives?

Advance directives fall into two general categories: instructional directives (sometimes called living wills) and proxy directives (also called durable powers of attorney). Instructional directives contain instructions regarding treatment and care in specified medical situations. Proxy directives delegate medical decision-making authority to a specified person. Hybrid forms of advance directives, combining elements of both types of directives, can be found in most jurisdictions. In all advance directives, the legal instrument becomes effective when a patient loses decision-making capacity; generally a formal legal finding of incompetence is not necessary.

Advance directives serve to extend the realm of patient autonomy, by providing a legal vehicle by which patients' decisions and preferences can determine treatment during times in which they are unable to make legally effective decisions. They can also be helpful in facilitating treatment by avoiding the delays and costs of guardianship or other legal procedures that may be necessary to provide care for incompetent patients.

A number of states (25 at the time of this writing) have adopted laws that specifically authorize PADs and define their application. In general, these statutes serve two broad functions. First, they reinforce the legitimacy of applying advance directives to psychiatric patients and psychiatric care. Second, they provide clarification regarding the limits of advance directives in psychiatric settings, where the legal framework regarding involuntary treatment and incapacity often differs from that governing medical and surgical care.

Common features of specialized PADs statutes:

1. Specialized PADs statutes typically leave existing state laws regarding hospitalization (both voluntary and involuntary) outside the reach of advance directives. Patients may not remove themselves from the reach of involuntary civil commitment law via an advance directive. Typically, voluntary admission procedures are also left intact, so that advance directives may not be used to bring a protesting, incompetent patient into the hospital without invoking the commitment statute.
2. These statutes typically leave intact existing state procedures that govern the right to refuse treatment and to over-ride refusal. In states that rely on determining treatment course based on substituted judgment (i.e., what the patient would want, if competent), an advance directive will have significant evidentiary weight.
3. Psychosurgery and ECT generally are not allowed to be authorized by a PAD.
4. The process of determination of decisional capacity is defined. In general, these statutes place determinations of capacity in the hands of clinicians, and do not require judicial declarations of incapacity before the PADs become operative.
5. State PADs statutes provide broad discretion--in the form of legal immunity--to psychiatrists to disregard patients' or surrogates' directives that are contrary to accepted clinical practice and medical standards.

There is considerable variability from state to state regarding the use of advance directives for psychiatric treatments. Psychiatrists are advised to inform themselves regarding their state's laws and practices.

Psychiatric Advance Directives: Uses and Advantages

Current practice relies heavily on formal procedures, such as guardianship, or judicial orders, for providing treatment to incapacitated patients. And presently, psychiatrists may accept dubious consent to treatment from seriously disordered patients, rather than invoke formal mechanisms. These approaches are problematic. Involuntary procedures may lead to adversarial relationships between patients and psychiatrists, often delay the initiation of treatment, and have significant economic costs. Guardianships are costly, difficult to revoke to revoke, and also entail lengthy procedures. The alternative, acceptance of dubious consent, is fraught with danger: in the event that a patient is later judged to have been incompetent to consent, the treating psychiatrist risks expensive and career threatening legal consequences.

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Psychiatric advance directives may be useful at a number of critical junctures in treatment:

1. To facilitate the provision of treatment to patients before hospitalization is necessary.
2. To provide advance authorization for hospitalization when patients lack capacity to consent.
3. To provide evidence of the prior wishes of the patient regarding hospitalization at commitment hearings.
4. To facilitate the provision of treatment to refusing patients during hospitalization. In some states, the wishes of the patient while competent are part of the judicial determination of whether to override refusal.
5. To provide evidence of valid consent for patients who accept medication while symptomatic and possessing uncertain decision making capacity.

In addition, the process of obtaining PADs is likely to have a number of beneficial consequences. First, when PADs are formulated as a collaborative process it leads to enhanced communication between the psychiatrist and patient. Second, many patients feel empowered and become more engaged in treatment as a result. Third, the process of formulating and honoring PADs may strengthen the therapeutic alliance. It is reasonable to project that the long term care of patients, over the course of recurrent illness, is likely to result in improved clinical outcomes, greater patient satisfaction, and a more positive attitude toward treatment providers. For the significant number of patients who experience relapse and rehospitalization, PADs may prove to be a means of reducing emotional trauma and feeling more in control.

A few studies have examined patients' formulations of PADs. Srebnik and colleagues examined the advance directives of 106 community mental health center outpatients with a history of at least two psychiatric hospitalizations or emergency room visits in the last two years (Srebnik et al, 2005). Patients received a trainer's instruction and assistance in using a software program to formulate PADs. Nearly half (46%) designated a surrogate decision maker. More than 80% specified medications that they would prefer, 64% medications they would refuse (often first generation antipsychotics), and 68% listed preferred alternatives to hospitalization. Nearly all specified a preferred facility, should hospitalization become necessary; half listed a facility to be avoided. Patients indicated that they would refuse ECT (72%) and specified a de-escalation method as preferable to seclusion and restraint (89%). Over 40% of patients indicated that they were not willing to take medications not listed specifically in the advance directive. With the exception of this item, more than 95% of the PADs were judged to provide instructions that were feasible, useful, and consistent with practice standards.

Swanson and colleagues (2006) randomly assigned 469 patients with severe mental illness to two groups. The experimental group members were to meet with a facilitator who would assist in the drafting of a PAD. The other group served as a control. More than 60% of the patients in the experimental group drafted a PAD (84% of those who actually met with the facilitator as instructed). Nearly all patients (99%) specified symptoms of impending mental health crisis. And a majority documented preferences regarding hospital facility, either providing advance consent for admission to one or more hospitals (89%) or refusal of admission to specified hospitals (62%). Regarding medications, patients gave advance consent to (93%) and refusal of (77%) of specific drugs. No one refused all medication. The PADs formulated in this study were rated as feasible and consistent with community practice standards regarding medication instructions (91%), hospital preferences (83%), and clinical information (94%). At 1-month follow-up, patients who had participated in the facilitated sessions were found to have superior working alliances with their clinicians and were more likely to report they were receiving needed mental health services.

In both the studies described, patients used the PADs to provide useful information not directly treatment related. In both studies, many patients provided emergency contact information for family, friends, and clinicians. Sbrenik and colleagues report that PADs included information regarding assistive devices (e.g., hearing aids, walkers), the care of finances, children, and pets during hospitalization, and dietary preferences.

There has been very little litigation regarding the use of PADs or their enforcement. However, one recent case raises questions about the permissibility of stand-alone PADs laws. Vermont had enacted a statute allowing committed psychiatric patients' advance directives to be overturned under certain circumstances. The U.S. Second Circuit found, in Hargrave v. Vermont (340 F. 3d 27(2nd Cir 2003)), that this law discriminated against committed patients with respect to advance directives and therefore violated the Americans with Disabilities Act. Whether the reasoning of this case becomes accepted by other courts remains to be seen. Whether or not its reasoning is sound, however, it may be wise to incorporate advance directives for mental health care into the state's general health care decisions law rather than adopting a stand-alone statute.

Conclusion

There are many reasons to believe that PADs will be useful in promoting patients' participation in decision-making, their experience of clinical care, while improving the treatment process and outcomes. The use of PADs is likely to increase, and patients will seek information and assistance from their psychiatrists. Thus, psychiatrists should familiarize themselves with state laws regarding advance directives, particularly in the growing number of jurisdictions that have adopted specific PADs legislation. Mental health systems will need to take steps in preparation for keeping track of patients' directives and monitoring compliance with their instructions. Undoubtedly, as the research literature and clinical experience grow, there will be greater understanding of how to best implement PADs.

References

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National Resource Center on Psychiatric Advance Directives: Getting started, http://www.nrc-pad.org/content/section/6/41/, downloaded 3/15/2009.

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Swanson JW, Swartz MS, Elbogen EB, Van Dorn RA, Ferron J, Wagner HR, McCauley BJ, and Kim M: Facilitated psychiatric advance directives: a randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. Am J Psychiatry 163:1943-1951, 2006

Resources

The following websites are valuable resources for learning about ongoing legal and clinical developments in the use of PADs. Some of the sites also include model forms and tips regarding the implementation of PADs.

The Bazelon Center
http://www.bazelon.org/issues/advancedirectives/index.htm

Duke University Program on Psychiatric Advance Directives
http://pad.duhs.duke.edu/

Mental Health America
http://www.mentalhealthamerica.net/go/position-statements/23

NAMI
http://www.nami.org/Template.cfm?Section=Issue_Spotlights&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=5&ContentID=8217

National Resource Center on Psychiatric Advance Directives
http://www.nrc-org