

# Commentary: Toward Resolving Some Dilemmas Concerning Psychiatric Advance Directives

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Dilemmas about when psychiatric advance directives (PADs) should be overridden are complicated by conflicting legal frameworks that may nonetheless operate concurrently—a legal scheme based on decision-making capacity (or competency) set against a legal scheme based on civil commitment, in which the latter may “trump” the former. A single statute in which the strengths of both schemes are “fused” may be possible. There is evidence that the promise of PADs in enhancing patients’ control over their treatment can be achieved without legislation for PADs and where civil commitment is given legal precedence. An example is the “joint crisis plan” in which, through a negotiation facilitated by an independent third party, a joint agreement is reached between patient and service provider about what treatment should be given when, as a result of a relapse of mental illness, the patient loses the ability to make treatment decisions. This clinical instrument may significantly reduce later involuntary treatment.

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Swanson *et al.*<sup>1</sup> provide a most interesting exploration of the grounds for overriding psychiatric advance directives (PADs), both ethical and legal. We will comment on three aspects of advance directives that arise from their paper: first, some issues in law; second, the place of involuntary treatment within conflicting legal frameworks; and third, alternative forms of advance statements that would not prevail over clinicians’ powers under civil commitment legislation, yet may still prove effective.

By way of introduction, we should say that we work in jurisdictions where there is little doubt that PADs would be trumped by civil commitment legislation and where PADs are therefore not often made. The Mental Capacity Act 2005 in England and Wales,<sup>2</sup> in which advance refusals are given statutory force, excludes the treatment of mental disorders in those domains where the Mental Health Act of 1983<sup>3</sup> is intended to operate; that is, when a patient objects to treatment that is deemed necessary by clinicians in the interests of the health or safety of the

patient or for the protection of others. Although many have argued that the British Government’s proposed reform of mental health legislation for England and Wales should include an incapacity, incompetency, or impaired decision-making criterion, which would in turn be likely to enhance the efficacy of PADs (or “advance statements”), so far this proposal has been rejected. (For example, see Mental Health Alliance 2006,<sup>4</sup> an association of more than 70 organizations opposed to the recent Mental Health Bill 2004,<sup>5</sup> which includes the Royal College of Psychiatrists, the British Psychological Society, MIND, and the British Association of Social Workers.)

## Questions of Law

We are surprised at the discretion apparently extended to American clinicians to override a patient’s stated wishes if they violate “accepted standards of care.” As Swanson *et al.*<sup>1</sup> state, overrides based on clinical discretion threaten to undermine the fundamental basis of a PAD—that is, the idea that the PAD represents evidence of informed consent to future treatment, made by a patient when he or she has capacity, to be implemented later when capacity is compromised. What trust can patients have in the

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process if doctors have such discretion to override their decisions?

Although we are not American lawyers, we consider it possible that the authors have misconstrued the effect of “immunity” clauses of the kind included in the new Pennsylvania PAD legislation. In our view, immunity clauses should not be viewed as conferring a power on clinicians to treat unwilling patients without their consent, because immunity clauses are not power-conferring provisions at all. We believe the authors are making an error in not distinguishing clearly between PADs involving requests for future treatment and those involving refusals of future treatment. The former can clearly be disregarded by clinicians when the request is for non-standard treatment, as no such request should be permitted to force a clinician to provide treatment against his or her better judgment. With regard to valid advance refusals, however, the matter is quite different. We believe that a clinician could only treat a patient involuntarily who had issued such a refusal when the clinician had a clear legal power to do so—conferred, for example, through civil commitment legislation—which could be relied upon to trump an advance directive.

Clauses conferring immunities on clinicians in advance directive statutes should not be read as conferring any such power of involuntary treatment: first, because immunity clauses are not directed at that situation, but at inappropriate requests for future treatment; second, because no legislation should be read to confer a power of involuntary treatment unless that meaning is abundantly clear, as a general constitutional principle; and third, because to read an immunity clause to confer such a power could produce the absurd outcome that a person who executed a PAD refusing treatment could end up having lesser rights to refuse treatment than those who have not completed an advance directive at all.

The decision in *Hargrave v. Vermont*<sup>6</sup> might therefore be criticized if it takes the position that even a power of treatment derived from a civil commitment statute cannot trump a valid advance refusal. But it could still be considered a perfectly sound decision to the extent that it supports the general principle that only clear powers provided by law can authorize involuntary treatment of objecting persons. An advance directive refusing future treatment is simply a valid way for a person to indicate an objection in advance.

## Involuntary Treatment in Conflicting Legal Frameworks

At a conceptual level, the content of a PAD should be considered just as one would a contemporaneous treatment request by the patient. The following questions would then arise:

- As in a contemporaneous request, does the patient have the necessary information to make a treatment decision? In the case of a PAD, this translates into the question of whether the patient foresaw the present circumstances sufficiently accurately at the time the PAD was formulated.
- As in the case of a contemporaneous request, a PAD seeking an inappropriate or unavailable treatment would not be met; or a request for a more expensive treatment option would be considered, but would not necessarily be met.
- In the case of an apparently imprudent contemporaneous treatment decision, attention would be drawn to the patient’s capacity (or competence) to make treatment decisions. Thus, if a PAD has been made, one would similarly ask whether the patient clearly had capacity at that time. Furthermore, the more serious the decision, the stronger the evidence that may be required that the patient did have capacity. How can the clinician now be satisfied that this was so, then? This consideration would suggest that the patient’s capacity at the time of making a PAD needed some form of assurance, with an added degree of rigor if there were a risk of serious harm.
- Where there is a risk of suicide, the approach to a PAD treatment refusal would be the same as a contemporaneous treatment refusal. How should we respond to a high risk of suicide in a patient who retains decision-making capacity? If it were the case that the state’s interest in preventing suicide were to override contemporaneous, competent treatment refusals, the same would apply to a PAD. Similar considerations would apply where there is a risk of serious harm to others (except that there is an alternative regime that might be called on: the criminal justice system).

But there is a problem here. These questions make sense when the framework for contemporaneous de-

cision-making mirrors that for PADs. But that is not the case. Psychiatrists, faced with a patient who is rejecting treatment and where involuntary treatment (usually involving hospitalization) is being considered, do not need in the majority of jurisdictions to assess the patient's decision-making capacity. Contemporaneous decisions in psychiatry are made within a legal framework based on civil commitment, whereas PADs derive from a framework based on decision-making capacity. At least in the United Kingdom and Australasia, the former regulates treatment not on the basis of the patient's capacity to make decisions, but on clinicians' (or judicial) judgments that the patient meets the civil commitment criteria, which are usually based on the presence of serious mental disorder and a significant threat of harm to the patient or others. The incapacity (or incompetency) scheme, on the other hand, is the framework applied in other areas of medicine, with psychiatry being the exception. This framework privileges a patient's autonomy in a way that civil commitment legislation does not. Patients, provided they have capacity, are allowed to refuse treatment, even if the outcome may appear to the clinician to be dire, yet avoidable. The separate cultures of the two legal frameworks contribute to the tense marriage described by Swanson *et al.*<sup>1</sup> The bizarre, and ethically problematic situation exemplified in *Hargrave v. Vermont*, in which a patient can be detained on the grounds of mental disorder, but cannot be treated because of a PAD (or because he or she retains capacity), is possible because of serious incompatibilities in the two frameworks based in separate sets of principles.

In an attempt to develop a principled and non-discriminatory approach to mental health legislation, we have proposed a "fusion" of civil commitment and capacity legislation into a single legislative scheme.<sup>7</sup> Such legislation would cover both "physical" and "mental" disorders (because the distinction does not stand careful scrutiny). It draws on the respective strengths of both frameworks. Capacity-based legislation is based on the proposition that the justification for involuntary treatment is the lack of capacity of the patient to make treatment decisions, whatever the causative disorder, "psychiatric" or "non-psychiatric." For the patient who lacks capacity, treatment decisions are then made by a substitute decision-maker, in the patient's "best interests." In England and Wales, the Mental Capacity Act of

2005, which was over a decade in gestation, provides well-honed, practical definitions of "capacity" and "best interests." Our proposal is that the definition of capacity in that Act should form the basic justification for all involuntary treatment in a "fused" Act.

However, a weakness of capacity-based schemes is the lack of attention paid to rules governing emergency treatment, conveyance to and detention in hospital, and the use of force in securing treatment. But these are precisely the strengths of civil commitment schemes, which should therefore also be incorporated in a "fused" act. While there are some complexities concerning the management of mentally disordered offenders who retain capacity, we propose a set of principles that would balance public protection against decision-making capacity.

### Alternative Forms of Advance Statement

In the United Kingdom at present, in the absence of any scope for PADs that would take precedence over the treatment powers conferred by civil commitment legislation, other approaches to taking account of patient treatment preferences have been developed. Indeed, noting the limitations of PADs in America described by Swanson *et al.*,<sup>1</sup> we wonder whether many, or even most, of the ostensible advantages of PADs may be achieved in this way. A structured expression of patient preferences for future treatment can be attained via two main formats in the UK—through "crisis cards" (CCs) or "joint crisis plans" (JCPs). (Some might argue that the Care Programme Approach,<sup>8</sup> in mental health—a standardized NHS format for assessment of needs, which includes a defined "care plan" that the patient should sign—should achieve a similar objective, but in practice the views of the service provider remain dominant.)

In the case of CCs, patients state their treatment wishes without reference to the service provider. Although advocated by some patient groups, their uptake has been very limited. In contrast, the JCP involves a particular kind of discussion (or negotiation) between the patient and the service provider and seeks agreement on what should be done in the case of relapse. Those involved in the discussion include the patient; a relative, friend or advocate; the patient's care coordinator; the psychiatrist; and, most important, an independent facilitator—to date, a mental health professional but with no association with the clinical team. The role of the last is to ensure

that the patient's wishes are heard, and that he or she has the last word on what should be included in the JCP, including its wording.

A successful discussion results in an agreement between the patient and service provider on the terms of the JCP. The content of a JCP in fact usually comprises much more than a statement of treatment preferences or refusals in the event of a crisis. It may include early signs of relapse, what measures might be helpful or unhelpful at an early stage, what treatments have worked or not worked when relapses have become established, who should be contacted, when admission would be appropriate, drug allergies or adverse effects, and practical needs (for example, who should look after a pet if hospitalization is necessary). The JCP's specificity of content, based on a collaborative analysis of past illness episodes, is a great strength. It is made clear to the patient and advocates that the powers of treatment provided by the Mental Health Act could prevail over the instructions contained in the JCP, but that the treatment team will endeavor to the best of their abilities to follow the agreed crisis plan. If agreement cannot be reached, a CC remains an option, or it may be stated in the JCP, with the patient's approval, that a particular treatment preference has not been agreed on by the clinical team.

A randomized controlled trial of JCPs has now been conducted in England.<sup>9</sup> Almost 40 percent of patients who were eligible—those with a psychosis and at least one admission to the hospital in the previous two years—took up the opportunity to complete a JCP. Had the study gone longer, more would probably have participated. The study found that the rate of compulsory admissions to the hospital was halved among patients with JCPs, a significant difference. There was a nonsignificant trend for reduced hospitalizations. Although the numbers were small, there was also a significant reduction in violent incidents in the JCP group. An earlier qualitative study found that patients who had JCPs reported that their

advance statements were uncoerced, that they felt more empowered and more in control of their treatment, and they would recommend JCPs to others.<sup>10</sup>

These are promising findings. They show that patients can effectively voice their treatment wishes outside a legal framework, and that agreements between patients and service providers about future care, as in JCPs, can result in improved outcomes. The dialogue between patient and service provider is probably a critical success factor. We believe that JCPs could be a useful option even in jurisdictions where PADs are possible. They may also be able to exist alongside legislation permitting involuntary outpatient commitment, where they could be regarded as a less restrictive alternative.

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