

[Excerpted from Swanson JW, Swartz MS, Hannon MJ, Elbogen EB, Wagner HR, McCauley BJ, Butterfield MI (2003). Psychiatric advance directives: A survey of persons with schizophrenia, family members, and treatment providers. *International Journal of Forensic Mental Health*, 2, 73-86.]

What are psychiatric advance directives? Where did they come from?

Psychiatric advance directives (PADs) are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment, in preparation for the possibility that the person may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness (Appelbaum, 1991; Winick, 1996). All states permit some form of legal advance directive (AD) for healthcare, which can be used in conjunction with at least some forms of psychiatric treatment. Typically, these instruments authorize a surrogate decisionmaker with Durable Power of Attorney for Healthcare to act in accordance with an incapacitated patient's previously-expressed wishes, known values, or to act in the patient's best interest if the patient's preferences are unknown.

ADs generally were designed to control decisions about end-of-life healthcare, e.g., to limit life-sustaining medical interventions that fail to provide a meaningful quality of life for terminally ill patients. However, these legal instruments have significant limitations when applied in the context of mental health treatment for incapacitated psychiatric patients. Some states' laws do not permit proxy decisionmakers to authorize certain types of mental health intervention (e.g., psychiatric hospitalization when the patient cannot give informed consent). And whereas some psychiatric patients might wish to pre-authorize treatment using an AD that is irrevocable during a crisis (i.e., when their decisional capacity may be impaired), most states allow medical patients to revoke their ADs even while incapacitated if they are able to communicate a choice to do so. Given these and other perceived limitations, [25] states in the past decade have adopted specific PAD statutes tailored for psychiatric patients who may experience fluctuating capacity to make treatment decisions. These instruments allow psychiatric patients to document in advance, while competent, their acceptance or refusal of particular types of mental health treatment and intervention. Some of these laws also incorporate authorization of proxy decisionmakers specifically for mental health treatment. In all of the new PAD statutes, revocation of

a PAD is conditioned on competency to make healthcare decisions; PADs remain legally in effect during periods of decisional incapacity (Fleischner, 1998).

Background. Over the past decade, two significant developments on the legal landscape surrounding patients' rights have generated increasing interest in PADs. First, the Patient Self-Determination Act (PSDA) of 1991 introduced a new set of federal requirements intended to implement advance directive policies at all healthcare facilities that receive federal funding through Medicaid and Medicare programs (Greco et al., 1991). Mental health-legal scholars and consumer advocates recognized that the PSDA had implications for psychiatric treatment, and also saw a potential opportunity in the PSDA to promote the empowerment of patient choice in mental health services (Hoge, 1994; Kapp, 1994)—notwithstanding concerns and evidence that medical advance directives are often ignored or ineffective (Howe, 2000; Teno et al., 1997; Wolf, 1991).

The PSDA requirements apply equally to psychiatric facilities and general hospitals, and include several key elements regarding advance directives. Specifically, healthcare facilities are obligated to: 1) inform patients of their rights under state law to make decisions concerning their own health care, including the right to accept or refuse treatment and the right to formulate advance directives; 2) document in the patient's current medical record whether or not the patient has an advance directive; 3) formulate policies for implementing patients' rights including the right to prepare advance directives, and inform patients in writing of these specific implementation policies; 4) ensure compliance with state law respecting advance directives; and 5) Provide education for staff and the community on issues concerning advance directives (United States Code, 2000).

The original intent of the PSDA was to ensure that patients know they have a right to prepare an advance directive to retain control over their future medical treatment if a time should come when they are unable to communicate their wishes directly. Patients are free to exercise that right or not, but advance directives do not abrogate hospitals' obligation to treat patients according to appropriate standards of care and practice; at the same time, hospitals cannot use their obligation to treat patients appropriately as an excuse to override a patient's advance directive.

Potential conflicts may arise between healthcare providers' perceived legal and ethical duties to provide the specific treatment that they

believe is best for patients, and their obligation to abide by patients' own wishes regarding acceptance of recommended treatment. Such conflict may become especially problematic in the case of individuals who suffer from severe psychiatric disorders, which may, at times, significantly impair judgment and the ability to recognize the gravity of one's condition and need for intervention (Halpern & Szmukler, 1997; Sales, 1993). Whether advance directives for mental health treatment will prove to be a help or a hindrance in resolving such conflicts is a matter of current debate, supported by opinions but sparse empirical evidence on either side. Preliminary studies of opinions about PADs suggest that these instruments are promising, but much more definitive research is needed (Amering et al., 1999; Backlar et al., 2001).

The second motivating force behind the rise of PADs in recent years has been the intense reaction in some quarters against policies of legally mandating psychiatric treatment (Lefley, 1993)— particularly outpatient commitment policies (Swartz & Swanson, 2002; Swanson et al., 2000). Outpatient commitment has been criticized as offering a perverse choice between coercion and neglect. In contrast, PADs appear to offer a more positive alternative: the possibility of both patient empowerment and beneficial treatment. Might the deleterious pattern of fragmented, intermittent, and often involuntary treatment be changed by advance planning on the part of persons with mental illness themselves? In theory, a PAD—and the process of preparing a PAD while competent—could facilitate engagement in the treatment process, help to mobilize clinical resources as necessary, improve adherence with beneficial therapies, facilitate communication between providers, caregivers and patients, and thus help to avert psychiatric crises or improve management of such crises without resort to involuntary commitment (Amering et al., 1999; Backlar & McFarland, 1996; Brock, 1998; Savulescu & Dickensen, 1998; Srebnik & La Fond, 1999; Stavis, 1999). Hoping for these benefits, [25] state legislatures to date have adopted specific PAD statutes—providing a legal means for persons with SMI to give advance instructions for their treatment during a future mental health crisis, and/or to appoint a proxy decisionmaker to carry out their wishes for treatment should they become incapacitated.

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