

# Commentary: Psychiatric Advance Directives as Tools for Enhancing Treatment of the Mentally Ill

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In this issue of the *Journal*, Swanson *et al.* explore the demand for and utilization of psychiatric advance directives (PADs), and discuss some of the barriers to their greater acceptance. This author suggests that PADs may be more widely accepted and utilized if they are viewed as tools for maximizing individual autonomy, with an emphasis on optimizing rather than merely restricting care.

**J Am Acad Psychiatry Law 34:58–60, 2006**

In 1983, Mary Beth Cruzan lapsed into a persistent vegetative state after suffering severe injuries in a motor vehicle accident. The argument over withdrawal of life supporting treatment measures received national attention, eventually culminating in the U.S. Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health*.<sup>1</sup> Ms. Cruzan was not the first patient whose treatment during a period of decision-making incapacity gave rise to struggles among family, friends, and numerous others, many with their own moral/religious/political/emotional axes to grind. Nor has she been the last. There has been a steady stream of such cases on the national scene over the past 30 years, starting with Karen Ann Quinlan<sup>2</sup> and extending to the spectacle in 2005 of the *Terri Schiavo* case.<sup>3–7</sup>

These headline-grabbing cases have all involved acute loss of decision-making capacity due to a sudden neurological event, terminal illness, or injury. They have captured the attention of the legislators, as well as the public, giving rise to passage of the Patient Self Determination Act (PSDA) in 1990<sup>8</sup> and promulgation of regulations pursuant to the PSDA in 1991. The PSDA requires, *inter alia*, that patients be asked whether they have an advance directive or would like to execute one on admission to a facility or

joining a health maintenance organization that receives government funds. Even before passage of the PSDA, there was extensive discussion and promotion of living wills and other advance directives for catastrophic and terminal illnesses.<sup>9,10</sup>

Mental health professionals are familiar with the problem of treating patients who are incapable of making their own treatment decisions, yet consideration of advance directives for the mentally ill lagged far behind the movement to use them for other illnesses. Swanson *et al.*<sup>11</sup> point out in this edition of the *Journal* that advance directives began to receive attention “among mental health stakeholders” subsequent to passage of the PSDA. They provide a summary of the types of advance directives available and the diversity of features of these instruments across the states. It is interesting to note that some states have felt a need to carve out mental illness from the durable power of attorney (DPA) instruments (both general and health care DPAs) available in those states by creation of psychiatric advance directives (PADs).

The decision to create specific PADs, thus using a different advance directive mechanism for the mentally ill than for those with other illnesses, might be expected to reflect a given state's approach to the protection of the autonomy rights of the mentally ill. This is not necessarily the case. For example, on the one hand, Massachusetts requires a full adversarial proceeding to determine incompetence and judicial

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substituted judgment before an incompetent person can be treated, voluntarily or involuntarily, with antipsychotic medication.<sup>12</sup> On the other hand, it utilizes a health care proxy that applies to all medical care, expressly including treatment for mental illness, such as antipsychotic drugs and hospitalization.<sup>13,14</sup> While the Massachusetts Health Care Proxy allows for revocation at any time, the document serves as valuable evidence of a patient's treatment preferences while able to make decisions. This document can both speed court proceedings and help insure that the patient's preferences are honored.

The goals of advance directives, in all clinical conditions, are to optimize treatment and preserve the autonomy of the individual patient at a time when he or she is unable to express his or her treatment preferences. Swanson *et al.*<sup>11</sup> portray PADs "as perhaps the most promising alternative or remedy for the use of coercion in mental health services for adults with serious psychiatric disorders." They note that use of involuntary treatment measures in community mental health care "has galvanized opposition and fueled increasing interest in PADs, particularly among consumer advocacy groups prompting ideals of recovery, empowerment, and self-directed health care." They go on to describe the great potential PADs have for improving treatment by involving patients in their own care through consensus between clinician and patient. The remainder of the article provides interesting observations about the demand for PADs, and the characteristics of those who ask for and utilize them.

Swanson *et al.*<sup>11</sup> note that higher levels of insight are associated with increased use of PADs and offer several hypotheses to explain the "large gap between the ostensible desire for and actual completion of PADs." These include lack of social resources, barriers to completion caused by illnesses, lack of awareness of PADs by patients and clinicians, and failure on the part of states to commit resources to the implementation of PADs.

These are all reasonable hypotheses, but another should be considered. It may be the case that many patients, clinicians, and mental health systems are resistant to PADs because they are being promoted as methods to restrict treatment rather than optimize care. Patients vary in their diagnoses, the severity of their illnesses, and treatment preferences, as well as in their desires for advance directives and the degree of autonomy they want to exercise over treatment deci-

sions. For some individuals, the ability to protect themselves from receiving certain or all types of treatment is a primary objective. Advocates of patient autonomy legitimately support this approach, but we should not expect treating clinicians, health care systems, or family members of patients to promote enthusiastically an instrument used to limit treatment options for those with severe mental illness. Other patients may fear limiting their treatment options and may refuse a PAD out of fear that it will restrict the care they will receive in times of crisis. In addition, some patients may decline to execute advance directives because they do not anticipate ever being so ill as to be unable to make their own decisions.<sup>15</sup> Inquiries as to these and other concerns that may deter utilization of PADs would be of interest as an extension of this study.

While PADs may be used to limit care, they can also be used to insure the speedy delivery of treatment to patients who are induced by their illness to refuse treatment. This can be of special importance in those states that require extended administrative process or adversarial proceedings and judicial approval before psychiatric treatment for incompetent individuals. The following case example, based on a consultation by this author before the enactment of the Massachusetts Health Care Proxy statute, is illustrative of how advance directives can assist in the delivery rather than restriction of care for the mentally ill.

A young woman's illness was marked by ongoing but manageable delusions about Satan, punctuated by episodes of mania during which she refused food and water, believed that she was possessed, and refused all treatment. Historically, antipsychotic medication and electroconvulsive therapy (ECT) effectively controlled these episodes. During one exacerbation of her illness, she was involuntarily hospitalized, and a petition was filed with the court to have her declared incompetent and to get approval for involuntary treatment with antipsychotic medication and ECT. At the hearing, which was held three weeks after the petition was filed, she was able to convince the judge that she was competent and she was returned to the hospital without an approved treatment plan. She continued to refuse to eat or drink and shortly thereafter required emergency medical hospitalization. Upon notification of her medical deterioration, the judge found her incompetent and approved the proposed treatment plan, and she recovered. After returning home, the patient, relatives, and her treating psychiatrist inquired about a method to avoid such a medical crisis and entanglement in the protracted adversarial process that precipitated it. The patient was assessed for capacity to make treatment decisions and her treatment preferences, and a durable power of attorney was crafted

that specified the treatments she wanted to receive in the event that she became incapacitated. In the document, she specifically acknowledged that a component of her illness was refusal of those treatments that were most effective, and she specifically requested that she receive those treatments, listing those medications that she did not want to receive. The document was executed, and the treatment plan was put in place, serving as a safety net that allowed for earlier interventions by her relatives and clinicians and avoidance of subsequent involuntary hospitalizations. At follow-up several years later, the durable power of attorney was still working effectively.

Advance directives can protect all of us from unwanted, intrusive, or objectionable care, as well as from our own impaired judgment at times of illness. Given the benefits of advance directives, how do we increase their utilization, especially by those with mental illness? The answer may lie in emphasizing the wide variety of ways in which these documents can help to obtain an optimal level of care that is consistent with the individual's preferences. Such preferences can include permission for, as well as limitations on, treatment; they can include designation as well as exclusion of potential substitute decision-makers; and they can involve assumption of maximum personal control over decisions, as well as delegation of those decisions. In other words, they allow truly personal choice, as opposed to promoting political and social agendas that may be inconsistent

with the preferences of patients who want to receive treatment for their illnesses.

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