

Competency for Creation, Use, and Revocation of Psychiatric Advance Directives

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Psychiatric advance directives help promote patient involvement in treatment and expedite psychiatric care. However, clinicians are unsure of how to use directives, partly due to poor clarity regarding standards for capacity to create, use, and revoke them. This article recommends possible capacity standards. Capacity to create directives is a legal presumption, supported by empirical data. Standards are discussed for the subset of cases in which capacity assessment is needed. Use of directives may be triggered by incapacity to provide informed consent to treatment, although tailored, individualized points of activation may also be considered. In many states, revocation of a psychiatric advance directive requires adequate decision-making capacity. Setting a capacity standard for revocation presents challenges, however, in light of obstacles to providing treatment when revocation is attempted and the fact that many patients prefer revocable directives. As more directives are created and used, additional research and statutory refinements are warranted.

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Psychiatric advance directives are an emerging method of treatment planning designed to improve treatment and enhance patient autonomy.^{1–3} Analogous to health care advance directives often used for end-of-life decisions, psychiatric advance directives document patients' mental health treatment preferences in advance of acute symptomatology in which capacity for, and meaningful participation in, decision-making may be compromised.^{4,5} Directive instructions may include preferences about medications, electroconvulsive therapy (ECT), restraint and seclusion, hospitalization, methods of de-escalating crises, alternatives to hospitalization, persons to contact regarding care of dependents and household, and appointment of a surrogate decision-maker.

Psychiatric advance directives have been promoted by professional, self-help, and advocacy organizations.^{6–10} A state-by-state analysis of relevant statutes reveals that 21 states have statutes explicitly

authorizing the documents, and nearly all others permit the documents through their health care living-will and power-of-attorney statutes.^{11,12} Use of directives is hypothesized to decrease perceived coercion; increase treatment collaboration, motivation, and adherence; expedite crisis care; and reduce psychiatric hospitalizations.^{3,13–18}

Despite the potential benefits of psychiatric advance directives, there has been very little use of the documents. Use is somewhat hampered by clients' not knowing how to complete the documents and doctors' not knowing that the documents exist once completed—practical problems that can be mitigated with information and support from clinicians or peers.^{19–21} Equally challenging, however, is the lack of clarity regarding standards for capacity to create, use, and revoke a directive, making clinicians unsure of how to use the documents.¹² Indeed, one of the most frequently raised concerns of clinicians is that some individuals may lack the decisional capacity to complete psychiatric advance directives, even when their acute symptoms are in remission.^{16,22} The point of incapacity that would trigger use, or “activation,” of the documents is also unclear. Finally, clinicians question whether an individual should be able to revoke a psychiatric advance directive during periods of impaired capacity for decision-making.¹²

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In light of the aforementioned concerns, this article reviews the relevant literature, including controversies in the field and related findings from our own ongoing research regarding capacity to complete, activate, and revoke a psychiatric advance directive. How capacity standards are addressed by laws specific to psychiatric advance directives is also discussed. Optimal capacity standards are recommended. It should be noted that the term “capacity” is used in this article for describing functional decision-making abilities and “competency” is used when discussing legal or statutory standards for those abilities.

Capacity to Complete Psychiatric Advance Directives

Feasibility of Making Decisions Regarding Future Treatment

Some scholars question the validity of any type of future health care decisions, irrespective of decision-making capacity. Dresser,²³ for example, believes that individuals cannot know what their future health care wishes will be, because the clinical context of future decisions cannot be completely known. She emphasizes that the current wishes of patients, regardless of decision-making capacity, should take precedence over competent historic wishes. However, others contend that the potential benefit of advance directives in providing information regarding competent patient preferences and increased autonomy over health care decisions should outweigh questions about the precision of those preferences.²⁴ Fortunately, having precise information on which to base treatment decisions for psychiatric advance directives could be less of a problem than for health care advance directives. Although health care advance directives inform future circumstances that are typically unknowable, individuals creating psychiatric advance directives generally possess substantial experience and knowledge about interventions to include in a directive.

Assuming that meaningful treatment choices for future circumstances can be made, questions remain about the decision-making capacity needed to make those choices. Advance directives are completed while a person is not acutely ill, when adequate decision-making capacity could be reasonably expected. However, there is some doubt that people with serious mental illnesses ever have the capacity to make

reasoned treatment decisions.²² These concerns may be based on stereotypes; however, they may cast doubt on the perceived validity of psychiatric advance directives, which could, in turn, reduce the likelihood that they will be honored.^{16,22,25} Thus, it is important first to define the capacity needed to complete a psychiatric advance directive and then to determine whether individuals with serious mental illnesses can be presumed to have this capacity or whether formal assessment of capacity is needed.^{26–28}

Statutory Standards of Capacity for Completion of a Directive

Legally, all adults, including those with mental illnesses, are presumed competent to make health care decisions absent a judicial finding to the contrary.²⁹ In some states, laws specific to psychiatric advance directives underscore this presumption.³⁰

Most states with laws about psychiatric advance directives provide some definition of capacity to complete the documents. In five states, the standard for capacity is that the principal be of “sound mind”³¹; in five others, the person must be “competent.”³² Eight states specify that the person must “have capacity” or be an individual who is “not incapacitated,”³³ with capacity defined as the ability to provide informed consent, including abilities to receive and evaluate information about treatment alternatives. Louisiana goes further, requiring a physician- or psychologist-administered written “mental status examination,” that attests to the principal’s ability to make reasoned treatment decisions.³⁴

In states without statutes regarding psychiatric advance directives, the standard for capacity to complete a directive is unspecified. Clarity and consistency in defining capacity to create a directive are needed if clinicians, family members, and patients are to understand the circumstances under which the documents may be created.

Defining Capacity to Complete a Directive

Currently, there is no gold standard for capacity to complete psychiatric advance directives.^{22,35} As scholarship on standards for decision-making competence in clinical settings is only about three decades old, the absence of a standard is not surprising. However, since the seminal work of Roth *et al.*³⁶ and others,^{37,38} a framework for treatment decision-making capacity that can be applied to the capacity to complete advance directives has been developed.³⁹ The model, developed by Appelbaum and Grisso,⁴⁰

is based on the most extensive⁴¹ review of legal, ethical, and empirical literature to date. It is now the most widely used framework in empirical studies of decision-making capacity in persons with chronic mental disorders.⁴¹⁻⁴⁶ The model describes decision-making capacity that comprises four functional abilities. They are the abilities to: (1) express a choice, (2) understand the facts of the decision-making situation, (3) appreciate and apply the significance of the information for one's own situation, and (4) reason and engage in a logical process of weighing options. For completion of psychiatric advance directives, these abilities should be shown within two decision-making areas: creating the directive itself and the substantive treatment choices specified within the document.

We recently developed an instrument to assess understanding, appreciation, reasoning, and expression of a choice for these two decision-making areas. Specifically, the first section examines the decision to create a directive. It includes questions about recognizing that the directive is to be used during future periods of impaired decision-making and that the document and any appointed surrogate decision-maker will be consulted for treatment decisions on the person's behalf. The second section assesses capacity for making treatment decisions within a psychiatric advance directive. Because information regarding future clinical circumstances and treatment options is not available, assessment of this capacity is based on understanding, appreciation, reasoning, and choosing for one prototypical scenario about whether to choose hospitalization or an alternative to hospitalization, such as a supervised crisis unit or residential facility. Such scenarios and educational interventions presenting available options can enhance understanding, which may be particularly useful for eliciting decisions regarding complex or unfamiliar treatments such as ECT or medication options.^{43,44} However, such interventions must be carefully designed so as not to bias for or against traditional or nontraditional interventions.

Testing the Presumption of Capacity to Complete a Directive

In a recent study, the instrument just described was administered to 80 outpatients with severe mental illnesses and histories of repeated admissions to psychiatric hospitals and emergency services. While the sample had an average Global Assessment of

Functioning⁴⁷ score of 30.7 ± 9.1 , indicating major impairment in several areas of functioning,²⁶ median scores approached maximum possible scores for understanding, appreciation, and reasoning scales, demonstrating adequate decision-making capacity. These findings are consistent with another study in which 82 percent of 28 individuals with severe mental illnesses correctly understood key concepts related to psychiatric advance directives.⁴ Regarding treatment decision-making more broadly, Palmer and colleagues⁴² have shown that people with schizophrenia in assisted-living residences in the community showed very little decision-making impairment. Their understanding was diminished compared with that of control subjects, but appreciation and reasoning were not.⁴² Other studies support these findings, but also demonstrate that individuals with serious mental illnesses show tremendous heterogeneity in capacity.^{48,49} Taken together, the data suggest that most people creating psychiatric advance directives in the community have sufficient decision-making capacity. Thus, the legal presumption of competency to complete psychiatric advance directives appears to be reasonable.

Given a presumption of competency to complete a psychiatric advance directive, is there ever a time when formal assessment of decision-making capacity is warranted? We contend that routine assessment is not warranted for several reasons. First, as noted, the data suggest that most people will have capacity sufficient for completing a psychiatric advance directive. Second, routinely assessing capacity is burdensome to both patients and clinicians. Finally, individuals completing the documents should not have to submit to such assessment routinely when there is no comparable requirement for individuals creating health care advance directives. Instead, assessment of capacity should be conducted when doubts preexist or arise about a person's decisional capacity, based on available clinical information, such as from collateral contacts or observation of cognitive or behavioral disorganization. Such judicious use of capacity assessment may encourage clinicians to have better trust in the content of psychiatric advance directives.²⁶ That said, there are still prejudices. Some clinicians may presume that clients who are involuntarily committed have impaired decision-making capacities, which may also have been impaired when an advance directive was created. As

such, documenting capacity at the time of completion of a directive could prove useful.

Third Party Statements of Capacity to Complete a Directive

Third party statements attesting to a person's capacity to create a psychiatric advance directive can provide documentation of capacity. Witnesses signing directives are typically required to attest that the principal appears to be of "sound mind."⁵⁰ Minnesota witnesses attest that the principal "understands the nature and significance of the directive."⁵¹

Witnesses to advance directives are typically friends or family, as clinicians are generally precluded from serving as witnesses.⁵² Psychiatrists or clinicians may informally attest to the decision-making capacity of the person signing a directive.^{25,53-55} In a survey of 74 clinicians, conducted by the first author, over 90 percent responded that they would be more likely to support decisions in a directive if a psychiatrist or clinician signed as to the decision-making capacity of the patient at the time of completing the document. As noted earlier, Louisiana's statute requires a "mental status examination,"²⁶ but such a requirement for a physician's statement of patient capacity is not recommended because it presents a potential barrier to completing a directive. This requirement could also be construed as discriminatory, as there are no comparable requirements for those wishing to complete health care advance directives. As such, witness and physician statements may bolster evidence of capacity, but should not be required.

Capacity for Activating Psychiatric Advance Directives

At what point should advance directives be activated and referenced for treatment decisions? First, a physician or other clinician must be aware of the existence of the document during a patient's mental health crisis. This can be facilitated by providing a completed directive to family, friends, and treatment staff and by having someone who knows of the document involved with the client during crises. Assuming that clinicians are made aware of the directive, the circumstances under which the directive should be activated and used must still be determined. The prototypical case of incapacity triggering use of advance health care directives is for individuals who are unconscious or otherwise unable to express even the most basic decision-making capacity—the ability to

express a choice. In this case, the necessity of using a directive to determine a person's health care wishes is obvious. In contrast, there are many disorders (e.g., delirium, substance-induced intoxication, and mental illnesses), characterized by fluctuating decision-making capacity, for which the point that a directive should go into effect is less clear. For clinicians and patients to feel confident in knowing when directives should be used, clarity regarding the activation point is needed.

Statutory Definitions of Capacity Akin to Capacity for Informed Consent

In states with statutes regarding psychiatric advance directives, the documents are typically activated when a patient becomes "incapable," as indicated by the inability to receive and evaluate information to make mental health treatment decisions.⁵⁶ Determination of incapacity is made by some combination of a treating physician, psychiatrist, mental health clinician, or court. This definition corresponds well to the capacity to provide informed consent for treatment, including the abilities of understanding, appreciation, and reasoning described earlier. It also makes sense clinically, as advance directives are generally intended to go into effect when a person cannot otherwise make the kinds of treatment decisions that are outlined in the directive.

An evaluation of decisional (in)capacity to provide informed consent—or to activate a directive—should incorporate evaluation of the risks and benefits of treatment decisions.³⁹ The risk-sensitive approach is common clinical practice, and it is the policy stance of relevant professional organizations and commissions.^{57,58} The approach notes that when the risk of negative consequences from a decision markedly outweighs the positive consequences, determining a person to be incapacitated should be considered. However, this risk-sensitive approach does not simply base capacity on whether a patient agrees with a recommended treatment. Specific decision-making abilities must still be evaluated. If agreement becomes the sole criteria for capacity, acquiescent but truly incapacitated patients may be deprived of the process of fully informed consent,⁵⁹ and for our purposes, also of using a directive.

While states with relevant directive statutes typically tie incapacity for activating directives to abilities to make informed consent, in other states the activa-

tion point of a directive is less clear. There are four alternative activation points, each with implications for the range of circumstances in which directives will be used.

Judicial Determination of Incompetency for Directive Activation

The most conservative approach is to use an advance directive only when there has been a court determination of ongoing decisional incompetency, such as with appointment of a guardian. This approach is straightforward and provides a bright line as to when directives take effect. However, because few people, even among those with severe and persistent mental illnesses, have a guardian, psychiatric advance directives would very rarely be used. Thus, use of directives is not limited in this way in any laws relevant to advance directives. However, use of psychiatric advance directives is also not precluded under conditions of guardianship, provided the individual in question created the directive while capacity to do so was intact.

Activation at Involuntary Commitment

A slightly less restrictive application of psychiatric advance directives would be to use the documents whenever a patient has been involuntarily committed. Early proponents of psychiatric advance directives indeed conceptualized use of the documents to direct and/or preclude specific interventions during involuntary commitment.^{60,61} This application is appealing in its clarity; however, it raises important clinical and legal issues.

First, simply setting the activation point of directives to involuntary commitment equates lack of decision-making capacity with the dangerousness standard most often used for commitment—concepts that are starkly separated by law in many states. Alternatively, consistent with these laws, directives could be activated during involuntary commitment, but only when decision-making capacity is also deemed impaired. Directives could also be activated during involuntary commitments in states in which the standard for commitment is incapacity for decision-making. Furthermore, regardless of commitment status, directives can provide useful information, even if not formally activated. However, permitting use of directives only during involuntary commitment eliminates their value to direct methods of de-escalating crises and alternatives to hospitalization that may avert commitment altogether.^{3,18}

Consequently, of those states with laws regarding psychiatric advance directives, only Wyoming explicitly restricts their use to a hospitalization episode, and even their statute includes both voluntary and involuntary hospitalizations.⁶²

Tailored Activation

Greater support has been expressed for activating advance directives at a point specified by the creator of the document, as can be done in some states for activation of power of attorney.^{12,63,64} This “tailored” activation permits an individual to define prospectively the point at which she or he has lost the capacity to make informed treatment decisions. For example, a person may specify a desire to have the directive used when delusional comments are made or a large amount of money is spent in a short time, indicating a manic episode. Alternatively, an individual may specify that activation of a directive should be tied to use of crisis services or hospitalization. Over half of the 106 participants in our study ($n = 62$; 58%) chose to create a tailored activation point, most often being the time of crisis services or hospitalization.

Tailored activation permits the kind of individualized and proactive use of advance directives that advocates envision. When in crisis, many patients present for care who are not legally incompetent and do not meet criteria for involuntary commitment, but who nonetheless are unable or unwilling to make productive treatment decisions^{22,63} and who may therefore fall through the cracks of the treatment system. Instructions in a directive could be very useful in these situations.^{25,65} Further, a person may learn more about his or her behavior patterns from the introspection necessary to define the activation point—the point at which decision-making capacity is compromised.

Despite the potential benefits of tailored activation of directives, problems arise with applying the concept to clinical practice. First, mental illness episodes may not always present with similar behavior patterns. If the specified activation behaviors are not present, the document may not be used. Second, the activation point may simply be unclear if the person creating the directive cannot provide concrete behavioral descriptors. Third, tailored incapacity thresholds would differ across individuals. Thus for some people, the same behaviors would result in retaining decision-making capacity, and for others, treatment

decisions would be turned over to a directive and any appointed surrogate decision-maker.

Even more problematic, a tailored definition of incapacity may have an imperfect relationship to incapacity for treatment decision-making as defined by the inability to understand, appreciate, and reason, as described earlier. This discrepancy could lead to a directive's not being used for someone who truly lacks decision-making capacity, but simply does not demonstrate the specific activation behaviors. More troubling, a directive could be used when activation behaviors are present, but when the person, nevertheless, has retained decision-making abilities. In this situation, it could be argued that the patient's decision-making authority has been prematurely turned over to a directive and surrogate decision-makers.^{22,66}

Only Hawaii, Pennsylvania, and Washington have laws permitting tailored activation of directives, and they make no attempt to reconcile the relationship of tailored activation with clinically defined decision-making incapacity.⁶⁷ Unless there is such a reconciliation, psychiatric advance directives may not be used at all during outpatient treatment or voluntary hospitalization, because within these settings patients are assumed to have decision-making capacity sufficient to provide informed consent, negating the need for directives. Individuals creating directives with tailored activation should be advised of this risk. Additional legal guidance is needed to clarify whether a tailored definition of incapacity to activate a directive can put the document into effect before a person demonstrates incapacity to provide informed consent.

Playing the devil's advocate, one could argue, "what's the fuss?" about defining precisely when to activate and use psychiatric advance directives. If directive instructions largely agree with the patient's current wishes, there is no problem—the document can be used with patient input into treatment decisions. It is useful, nevertheless, to establish the point of activation of directives if only to determine which clinicians (e.g., outpatient, voluntary, or involuntary inpatient) should be prepared to use the documents and in which settings. But when directive instructions disagree with a patient's current wishes, the issue of whether to use the directive instead of the patient's expressed wishes is raised. This is the point at which a patient may attempt to revoke his or her directive.

Capacity for Revoking Psychiatric Advance Directives

A person with decision-making capacity can always revoke an advance directive. It is whether a person should be allowed to revoke a psychiatric advance directive when decision-making capacity is impaired and what the capacity standard should be that is the focus of debate.¹²

Rationale for Prohibiting Revocation During Periods of Incapacity

The consequences of health care advance directives can clearly be significant—sometimes resulting in life or death. This may be the rationale for laws that give individuals every opportunity to change or revoke health care advance directives. In contrast, psychiatric advance directives are used during temporary psychiatric crises. Many individuals with mental illnesses and their families know that acute mental illness symptoms can lead a person to revoke a directive and the well-reasoned treatment preferences expressed within it. All but five states with statutes specific to psychiatric advance directives prohibit revocation during periods of incapacity, to prevent directives from being dismissed during crises, just when they are needed most.⁶⁸ This "Ulysses clause," is named after the mythical Ulysses who asked his shipmates to bind him to the ship's mast and not to release him, even if he later revoked his decision, so that his ship could sail safely past the sirens whose song would otherwise lead the ship to destruction.^{23,55,69}

Defining Incapacity to Prohibit Revocation

In states that prohibit revocation of a directive during periods of incapacity, the criteria for capacity to revoke a directive is typically when the person is "not incapable" of making treatment decisions, using the same definition of incapable as is used for activation of the documents.⁷⁰ The statutes generally require some combination of a treating physician, psychiatrist, or mental health clinician to make a determination of (in)capacity.

It should be noted that equating the incapacity threshold to activate a directive with the incapacity threshold to prohibit revocation means that whenever the document is in use, it cannot be revoked. If a tailored definition of activation is used, however, directives could be used more proactively, but still could not be revoked when a person has truly lost

decision-making capacity. In either case, there is apparent statutory consensus that the standard for incapacity to prohibit revocation is consistent with the standard for (in)capacity to make treatment decisions, based on abilities to understand, appreciate, and reason. What is less clear is whether prohibiting revocation during incapacity is practical or even desirable.

Problems With Irrevocable Directives

The restriction on revocation during incapacity raises legal and practical problems. What should clinicians do when a person who appears incapacitated tries to revoke a psychiatric advance directive? Can directive treatment instructions be followed or enforced? If so, would such treatment be considered voluntary or involuntary? Only Washington's statute addresses these questions. The statute notes that treatment may proceed for an incapacitated patient attempting to revoke a directive. The directive may serve as voluntary consent for treatment for a protesting patient, only if physical force or restraint is not needed to provide treatment. Processes for determining capacity and the consequences of such a determination are specified. In other states that remain silent on these issues, the Ulysses clause may not provide the protections that advocates hope for. Without explicit statutory support for enforcing directive instructions against a protesting patient, clinicians are unlikely to do so unless the patient is independently adjudicated to be incompetent or meets criteria for involuntary commitment.⁶⁵

Although the issues surrounding revoking a directive may be legally thorny, it is important to note that even when revoked, instructions in a psychiatric advance directive can provide clinicians with valuable information about a patient's treatment preferences. The directive stands as the best evidence of what a patient would have chosen for treatment if decision-making capacity were unimpaired.⁶³ Furthermore, the concerns about revocation may be overblown, as clients rarely revoke directives. In our study of 106 clients with directives and their associated 487 crisis events, a directive has never been revoked as a whole, though in 105 (22%) of the crises, clients changed their minds about some specific instruction, most often the choice of whether to use hospitals or alternatives to hospitalization during a crisis.

The Case for Patient Choice

Typically not addressed in discussions of the pros and cons of restricting revocation of directives are the wishes of the individuals who create the documents. In our own study, only a scant majority (57%) of the 106 participants who created psychiatric advance directives did not want to be able to revoke the document while decision-making capacity was impaired.

Consistent with this split opinion, Arizona and Washington's psychiatric advance directive statutes allow individuals to choose whether they want a directive to be revocable or not during periods of decisional incapacity. In other states, will individuals who want a revocable directive simply opt out of the process? Will they feel coerced into creating a binding directive? If patient autonomy and choice over treatment are aims of creating and using psychiatric advance directives, providing a choice over whether the document is revocable seems reasonable.¹⁴ Further, until more is known about how revocation of directives by patients with impaired decision-making is treated clinically, states considering advance directive legislation should retain the option for patients to create a revocable or irrevocable directive.

Summary

We have presented possible standards for capacity to create, use, and revoke psychiatric advance directives and the strengths and problems in various approaches. Decision-making capacity to create a directive involves the same abilities as for providing informed consent to treatment, including understanding, appreciating, reasoning, and making a choice using information about available options. For psychiatric advance directives, these abilities must be assessed over decisions about creating a directive and the treatment interventions specified within the document. Evidence from use of a recently designed instrument to assess these abilities suggests capacity to create a psychiatric advance directive can be reasonably presumed, underscoring the legal presumption of capacity to complete directives. Formal assessment of capacity should be reserved for cases in which doubts have arisen about decisional capacity based on available clinical information.

The standard for decision-making incapacity that activates psychiatric advance directives dictates the extent to which directives will be used during crises

broadly and proactively or more narrowly. Setting incapacity that activates a directive to involuntary commitment or assignment of a guardian is overly restrictive. States with statutes regarding psychiatric advance directives define the activation point as a person's incapacity to provide informed consent to treatment. This definition is clinically familiar and reasonable, allowing the use of a directive when a person cannot otherwise make the types of decisions specified in the document. Tailored, individualized points of activation may allow for earlier, proactive use of the documents; however, tailored activation points may be unclear, variable across persons, and inconsistent with clinical standards for decisional (in)capacity. To make tailored activation feasible, laws regarding psychiatric advance directives should explicitly reconcile the tailored concept of incapacity to activate a directive with clinical determinations of incapacity to consent to treatment.

Revocation of a psychiatric advance directive is prohibited during periods of decisional incapacity in most states in which the issue has been considered. Incapacity is defined as the inability to make informed treatment decisions; the same definition that is used to activate the document in most states. Supporters of this prohibition believe it will prevent individuals from rejecting, due to acute psychiatric symptoms, the thoughtful choices specified within a directive. However, whether and how clinicians may provide treatment for an incapacitated person who revokes a directive is typically left unaddressed. Psychiatric advance directives may be rarely used in these situations in the absence of clear statutory guidelines about how such treatment can proceed and whether it can be considered voluntary. A substantial proportion of patients also prefer directives to be revocable at any time. Therefore, until more is known about the treatment implications of prohibiting revocation, in states considering advance directive legislation, it would be prudent to allow patients to choose whether to create a revocable or irrevocable directive.

We have presented the relevant literature and the only empirical data available regarding decision-making capacity with respect to psychiatric advance directives. Such limited findings leave to conjecture the ramifications of the various capacity standards described. While we have based some of our recommendations on the literature regarding capacity for providing informed consent for treatment,^{39,42,48,49} determining optimal standards for decisional capac-

ity to create, use, and revoke psychiatric advance directives will only occur through information gleaned as more directives are created, used, and studied.

These cautions should not, however, deter the creation and use of psychiatric advance directives. As noted, the capacity to create directives may be safely presumed for the great majority of individuals. Only a small fraction of patients may require formal assessment of capacity. Use of directives is also not dependent on complete precision with regard to defining capacity to activate or revoke them. Psychiatric advance directives provide critical information about effective interventions and patient's treatment preferences. Regardless of the point of legal activation and revocation, psychiatric advance directives stand as the best evidence of a patient's competent treatment wishes. As such, psychiatric advance directives can function as a truly unique and valuable guide for clinical care.

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33. Arz. Rev. Stat. § 36-3221 to 36-3281; Mont. Code Ann. § 53-21-115 to 53-21-714; Ohio Rev. Code Ann. § 2531.01; Okla. Stat. Ann. 43A, § 11-101 to 11-113; Tex. Civ. Prac. & Rem. Code Ann. §§ 137.001 to 137.011; Utah Code Ann. §§ 62A-12 501 to 62A-12 504; Wash. Rev. Code § 71.32; Wyo. Stat. Ann. § 35-22-302 to 35-22-308
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