Psychiatric Advance Directives: What Psychiatrists Need to Know Now

April 11, 2013 | Forensic Psychiatry [1], Bipolar Disorder [2], Geriatric Psychiatry [3], Schizophrenia [4]
By Jether C. Farino, MD [5] and Kaustubh G. Joshi, MD [6]

This article explains and demonstrates the importance of psychiatric advance directives and the benefits and obstacles involved in implementing them.

CME credit for this article is now expired. It appears here for your reference.

At the end of this article, readers should be able to:
1. Describe the benefits of psychiatric advance directives (PADs) and the problems with their implementation.
2. Distinguish between the 3 types of PADs: the instructional directive, the proxy directive, and the combination directive.
3. Assess the limitations associated with PADs.

Psychiatric advance directives (PADs) are similar to medical advance directives except the focus is on mental health treatment decisions. PADs are increasing in favor among patients but are considerably underused compared with medical advance directives.

PADs were created as a result of several court cases from the 1970s and 1980s that focused on patient self-determination regarding medical and psychiatric care. These cases ultimately led to the Patient Self-Determination Act of 1990 (PSDA).1,2 This federal law requires Medicare and Medicaid providers to inform patients of state laws concerning advance directives; to ask whether the patient has an advance directive; and to inform the patient of his or her right to complete an advance directive. Since the PSDA was enacted, 25 states and the District of Columbia have added statutes to assist mentally ill persons in guiding their care when facing possible future decision-making incapacity.

PADs are a means to empower persons with mental illness by increasing autonomy and decreasing coercion in the treatment they receive. PADs allow an individual with mental illness, while competent, to describe early indicators of relapse; specify preferences for or against certain medications; weigh in on other treatment options that may or may not have worked previously; articulate acceptable trade-offs in treatment; give advance informed consent for treatment (including hospitalization when appropriate); and designate a surrogate to make future health care decisions on his or her behalf.3,4

**Elements of PADs**
The specific aspects of a PAD differ from state to state, but they generally contain the following guidelines5:
- Choice of medications, route of administration, dosage limitations
- Designation of treatment plan
- Preferences for a lengthier hospital stay versus more aggressive treatment considerations (or vice versa)
- Desires regarding unusual or experimental treatments
- Choices with respect to the use of nonpharmacological modalities (eg, electroconvulsive therapy)
- Designation of treatment setting and choice of physician
- Preferences regarding the management of emergency situations (eg, use of physical restraints, seclusion, chemical sedation)
- Plans for post-hospital discharge services and support services (eg, housing management)

PADs provide a means for patients to express their personal choices and make advance decisions about the treatment they want to receive during times of acute illness.5 PADs contribute to improved communication with providers, allow patients to have a role in their treatment, and allow for better relationships with family and caregivers. This can improve patient self-esteem, improve treatment...
compliance, and enhance the patient’s quality of life. Family members can better understand a patient’s illness, which may help them recognize early signs of illness.

There are 3 types of PADs: the instructional directive (eg, living wills), the proxy directive (eg, health care power of attorney), and the combination directive. Each type has its own strengths and weaknesses.

The strength of the instructional directive is that the patient’s wishes are written out clearly before he becomes incapacitated. The patient has a relative amount of reassurance that his wishes will be followed. This increases a sense of continued autonomy even in times of vulnerability. A weakness is that it might be too restrictive in scope and flexibility. A patient may be left with an outdated treatment regimen because the document has not been updated. In addition, unforeseen problems may arise for which solutions have not been clearly spelled out, thus leading to improvisation and potential conflicts between the patient, his family, and the physician.

The strength of the proxy directive is that it has more flexibility and it is easier to meet the changes or challenges that can arise during treatment. The patient appoints a surrogate that he knows and trusts, which enables a smoother transition of care if the patient loses decision-making capacity. However, a problem can occur if the surrogate’s decisions are not altruistic. In addition, there may not be a close family member or friend to serve as a proxy. In this case, a patient’s physician could serve as a proxy, but there is the potential for conflict of interest. Because the advance directive does not have the immediate oversight of a judge, some states explicitly forbid a psychiatrist to act as proxy.1

The combined directive has all the strengths of the other two directives and minimizes the weaknesses of each. The proxy portion gives broad decision-making authority to the patient’s substitute decision maker, who can use the instructional portion of the directive as proof of the patient’s wishes.3

A role for psychiatrists

Having a psychiatrist, team of mental health professionals, legal staff, or a facilitator versed in PADs able to interact with the patient increases the odds of compliance with a PAD. Although PADs are legal documents, consulting with an attorney to develop such a document may not always be feasible. A hospital team approach can decrease the time and expense in completing a PAD, although this is an area where additional research is needed. Psychiatrists could play a critical role in assisting patients in developing a PAD and facilitating their implementation in a timely and cost-effective manner.

When a patient is helped by hospital staff to fill out a PAD, the document is more likely to be completed.5 PAD software is available to facilitate the completion of a PAD. In a study that used the AD-Maker® software, patients were 200 times more likely to complete a PAD.6 Henderson and colleagues6 found that patients preferred to complete a PAD outside of the psychiatric ward or clinical setting and were more comfortable in an attorney’s office. Collaboration between hospital psychiatric and legal resources would likely allow more patients to have an advance directive. Although more research is needed, the best approach seems to be a collaboration between the patient, his proxy, his physician, and legal/hospital counsel.

Because of limited research, it is difficult to assess whether PADs are effective. One study showed that PADs are most useful in higher-functioning patients.7 This study found PADs were more likely to be accessed if the patient had an Axis II diagnosis or had a surrogate. During a crisis event, substance abuse/dependence or a history of prior outpatient involuntary commitment decreased a PAD being accessed by 4- and 6-fold, respectively. This is unfortunate because lower-functioning patients with prior involuntary commitments gain the most from a PAD to help guide effective treatment.

The solution to increasing the use of PADs is 3-fold: they need to be easily accessible; physicians need to be trained in their use and the surrounding legal issues; and health care bias about the legitimacy of PADs needs to end.

Swanson and colleagues8 found that PDAs were being completed by only 4% to 13% of patients. Srebnik and Russo7 found that a scant 20% were being accessed by providers. A useful tool is being wasted, and this does not bode well for the effective treatment of patients. To help mitigate this, some states have online registries or place symbols on drivers’ licenses to alert health care professionals that a patient has an advance directive. Organizations such as the Veteran’s Administration (VA) have PADs on file or use pop-up windows to alert providers when they access the patient’s electronic medical record.6 Another complicating factor is that most PADs are only available as a hard copy that needs to be carried by the patient. The potential consequences on patient confidentiality are dire should loss occur.
Legal and ethical issues

Psychiatrists who are viewed as advocates of a patient’s care and continued autonomy regardless of the patient’s decision-making capacity have a potentially unique responsibility to uphold a PAD. The biggest issue for providers when acknowledging PADS is provider bias and ignorance of the law. In one study, only 37% of physicians correctly answered a question about an aspect of North Carolina’s PAD statute; 50% of mental health providers thought the effect of a PAD would be a negative outcome for the care of the patient.9

It is difficult to know when a PAD can be overridden. The state that has come closest to protecting a patient’s wishes by not overriding a PAD is Vermont, where refusal of “usual treatments” is allowed for 45 days before a PAD is overridden in court. This 45-day period is set to provide enough time to allow the patient to improve before the PAD is overridden.10,11

It was feared that in writing a PAD, patients would opt out of all psychotropics. Srebnik and colleagues5 found that 81% of patients with a PAD had included medications, and although 64% listed medications they would refuse, none rejected all psychotropics. These findings indicate that the risk of a patient opting out of all medication is minimal. States may want to look at legislation to minimize the worst case scenario. For example, Pennsylvania’s statute includes 3 provisions that protect physicians from legal liability and have legal oversight when a PAD is overridden by the courts to protect abuses of the further erosion of a patient’s autonomy.12,13

One of the PSDA mandates requires that states and hospitals follow federal guidelines to make medical and educational forms easy for patients to understand. Mueller and colleagues14 showed that the literacy level of most advance directives was above the national average ability to read and comprehend. In fact, the average literacy level of the advance directives evaluated from each state was at a 12th grade level, thus potentially alienating 90 million individuals in the US whose reading level is below that of a high school graduate. Only 22 directives were at a 10th grade or lower reading level. Oregon’s was the most consumer-friendly, at a 7th grade level, but Utah’s living will and power of attorney forms were at a 19th and 18th grade level, respectively.

Another issue is the question of how much capacity is needed to complete a PAD and how should its assessment be implemented. Srebnik and colleagues15 found that few statutes require capacity to be assessed before a PAD is created. This may reinforce the difficulty of upholding a PAD if the patient’s capacity was questionable. However, the law presumes decision-making capacity until otherwise shown, and there are no set criteria as to what to assess.

Srebnik and colleagues15 used the criteria of the Competence Assessment Tool for Psychiatric Advance Directives (CAT-PAD) to assess competency. They argued that the CAT-PAD criteria were superior because they looked not only at capacity to make medical decisions but also at comprehension. Surprisingly, this study found assessing capacity may be unnecessary because patients in their 30s who had bipolar I disorder or schizophrenia still had the capacity to fill out their PAD. Others have used the Hopkins Competency Assessment Test. Backlar and colleagues16 reported that 82% of individuals with severe mental illness could correctly understand key PAD concepts. Patients view the PAD as their voice when they have none. Physicians and the courts agree to some extent but are given a large amount of leeway with involuntary commitment and compelling the use of medications. When can a court or physician, in good conscience, disobey a directive written in a patient’s legal document? Currently, where to draw this line is hotly debated. Ironically, a patient can have difficulty in overriding his own words in a PAD because of questions of capacity. Patients without treatment preferences in their PAD are subject to the proxy’s or physician’s clinical discernment.17,18 To help address this issue, some states, such as Washington, Hawaii, and Pennsylvania, have laws that allow for “tailored activation” of PADS, which permits an individual to define prospectively the point at which he has lost the capacity to make informed treatment decisions (eg, when delusional comments are made or a large amount of money is spent in a short time, indicating a manic episode).18

Clinical implications

Wilder and colleagues19 found that patients who specified a medication in their PAD were more likely to continue with that medication 12 months later compared with patients who did not have a PAD. Better medication adherence results in a decrease in emergency department visits and psychiatric admissions and improved quality of life. A patient who is experiencing a manic or psychotic episode can have difficulty communicating his wishes. The PAD helps guide the clinician to the most effective, expeditious, safe treatment that is in line with the patient’s wishes. Research suggests that many hospitals do not have a system in place for PADS to be stored and easily accessed, which makes it difficult to implement and use them. Some states and private companies have attempted to reconcile this by making living will registries accessible to patients.
and physicians. But as of 2009, only 12 states and 1 private company, US Living Will Registry, had registries.  

A VA hospital looked at possible blockades to using PADs. In spite of formal clinician training and readily available PADs, their use was limited to a fraction of actual cases. However, another study showed that physician education does make a difference; those who were more aware of the legal aspects of PADs were more likely to use them. Longitudinally, the longer PADs were used and brought to the attention of providers, the more often they were implemented.

**Conclusion**

It will take larger entities, such as hospitals and state governments, to make PADs more accessible and presented at a level that everyone can read and understand. In addition, clearer guidelines are needed on when a PAD can be overridden, to help in striking the best compromise for the patient and societal safety.

Much like the early legal battles in the 1970s and 1980s that led to an applicable advance directive document, a fair amount of time and contentious debate will be needed to allow mental health policies, local government procedures, and hospital policies to coalesce into an applicable and feasible process to fully implement PADs and their high degree of utility in patient care to positively affect quality of life.

**Note:** This article was originally published as a CME in the April 2013 issue of Psychiatric Times. Portions of it may have since been updated.

**Disclosures:**

Jether C. Farino, MD, has no disclosures to report.

Kaustubh G. Joshi, MD, has no disclosures to report.

Christine Wilder, MD, (peer/content reviewer) has no disclosures to report.

**Source URL:**


**Links:**