Psychiatric Advance Directive

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A psychiatric advance directive (PAD), also known as a mental health advance directive, is a written document that describes what a person wants to happen if at some time in the future they are judged to be suffering from a mental disorder in such a way that they are deemed unable to decide for themselves or to communicate effectively. It can inform others about what treatment they want or don't want from psychiatrists or other mental health professionals, and it can identify a person to whom they have given the authority to make decisions on their behalf. A mental health advance directive is one kind of advance health care directive.

Keywords: mental health ; mental disorder ; advance directive

1. Legal Foundations

Psychiatric advance directives are legal documents used by persons currently enjoying legal capacity to declare their preferences and instructions for future mental health treatment, or to appoint a surrogate decision maker through Health Care Power of Attorney (HCPA), in advance of being targeted by coercive mental health laws, during which they may be stripped of legal capacity to make decisions.[1]

In the United States, although 25 states have now passed legislation in the past decade establishing authority for PADs, there is relatively little public information available to address growing interest in these legal documents.[2] In addition in states without explicit PAD statutes, very similar mental health advance care planning can and does take place under generic HCPA statutes—expanding the audience for PADs to all 50 states (see National Resource Center on Psychiatric Advance Directives).

In addition, states are beginning to recognize legal obligations under the federal Patient Self-Determination Act of 1991, which includes informing all hospital patients that they have a right to prepare advance directives and—with certain caveats—that clinicians are obliged to follow these directives.

Finally, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requires behavioral health facilities to ask patients if they have PADs. The Centers for Medicare and Medicaid Services announced that patients have the right to formulate advance directives and to have hospital staff and practitioners who provide coercive interventions in the hospital comply with these directives. Hospitals out of compliance risk loss of Medicare and Medicaid revenue.

Proponents of these directives believe thy of followed by treatment providers, crisis planning using PADs will help involuntary detainees retain control over their decision making—especially during times when they are labeled incompetent. Additionally, advocates argue that health care agents will be instrumental in providing inpatient clinicians with information that can be central to patients' treatment, including history of side effects and relevant medical conditions.

2. Clinical Benefits

Recent data from a NIH-funded study conducted by researchers at Duke University has shown that creating a PAD with a trained facilitator increases therapeutic alliance with clinicians, enhances involuntary patients' treatment satisfaction and perceived autonomy, and improves treatment decision-making capacity among people labeled with severe mental illness.[3]

Moreover, PADs provide a transportable document—increasingly accessible through electronic directories—to convey information about a detainee's treatment history, including medical disorders, emergency contact information, and medication side effects. Clinicians often have limited information about citizens detained and labeled as psychiatric patients who present or are coercively presented and labeled as in crisis. Nonetheless, these are the typical settings in which clinicians are called upon to make critical patient-management and treatment decisions, using whatever limited data

may be available. With PADs, clinicians could gain immediate access to relevant information about individual cases and thus improve the quality of clinical decision-making—appropriately managing risk to patients and others' safety while also enhancing patients' long-term autonomy.

For these reasons, PADs are seen as an innovative and effective way of enhancing values of autonomy and social welfare for detainees labeled with mental illness. Since PADs are among the first laws that are specifically intended to promote autonomy among people detained under mental health laws, wider use of PADs would empower a traditionally disenfranchised group when targeted for coercive psychiatry.

3. Barriers

National surveys in the United States indicate that although approximately 70% of people targeted by coercive psychiatry laws would want a PAD if offered assistance in completing one, less than 10% have actually completed a PAD.[4]

Some people detained and forcibly drugged under coercive psychiatry laws report difficulty in understanding advance directives, skepticism about their benefit, and lack of contact with a trusted individual who could serve as proxy decision maker. The sheer complexity of filling out these legal forms, obtaining witnesses, having the documents notarized, and filing the documents in a medical record or registry may pose a formidable barrier.

Recent studies of practitioners of coercive psychiatry's attitudes about PADs suggest that they are generally supportive of these legal instruments, but have significant concerns about some features of PADs and the feasibility of implementing them in usual coercive intervention settings. Clinicians are concerned about lack of access to PAD documents in a commitment, lack of staff training on PADs, lack of communication between staff across different components of mental health systems, and lack of time to review the advance directive documents.

In a survey conducted of 600 psychiatrists, psychologists, and social workers showed that the vast majority thought advance care planning for crises would help improve patients' overall mental health care.[5] Further, the more clinicians knew about PAD laws, the more favorable were their attitudes toward these practices. For instance, while most psychiatrists, social workers, and psychologists surveyed believed PADs would be helpful to people detained and targeted for forced drugging and electroshock when labeled with severe mental illnesses, clinicians with more legal knowledge about PAD laws were more likely to endorse PADs as a beneficial part of patients' treatment planning.

However, many clinicians reported NOT knowing enough about how PADs work and specifically indicated they lacked resources to readily help patients fill out PADs. Thus, if clinicians knew more about advance directives and had ready assistance for creating PADs, they said they would be much more likely to help their clients develop crisis plans.

4. Resources

It thus has become clear that the potential significance of PADs is becoming widely recognized among those targeted for coercive psychiatry, survivors of coercive psychiatry, influential policy makers, clinicians, family members, and patient advocacy groups but that significantly more concerted efforts at dissemination were needed. The community of stakeholders interested in PADs and the broader concept of self-directed care are in need of online resource and gathering place for exchange of views and information.

As a result, in the United States, a collaboration between the Bazelon Center for Mental Health Law and Duke University has led to creation of the MacArthur Foundation-funded National Resource Center on Psychiatric Advance Directives, the only web portal exclusively devoted to developing a learning community to help people targeted for coercive psychiatry, their families, and clinicians prepare for, and ultimately prevent, coercive psychiatry interventions. The NRC-PAD includes basic information, frequently asked questions, educational webcasts, web blog, most recent research, legal analyses, and state-by-state information on PADs and patient-centered crisis planning. The NRC-PAD website thus includes easy step-by-step information to help those targeted for forced drugging, family, and clinicians complete PADs that mirror the provisions in the PAD statutes.

For other countries, see[6].

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