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Psychiatric Advance Directives

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Psychiatric advance directives (PADs) are legal documents that allow people to plan for mental health treatment in the event of an incapacitating psychiatric crisis. They are also sometimes called mental health advance directives (MHADs) or declarations for mental health treatment (DMHTs). Regardless of the acronym used to identify them, these documents are essentially the mental health version of healthcare advance directives (i.e., healthcare power of attorney), which are legal documents that allow people to plan for medical treatment in the event of an incapacitating physical health problem (e.g., a coma).

There are many similarities between the two types of advance directives. In both types of documents, individuals can detail what type of treatment they would prefer, note any interventions to which they specifically decline consent (e.g., electroconvulsive therapy [ECT] or intrusive life-sustaining medical treatments), and identify a substitute decision-maker they trust. These documents may only be validly executed when the individual has the capacity to make healthcare decisions. Sometimes the individual creating an advance directive has a personal or family history of incapacitating health events, but such a history is not mandatory. The requirements for valid execution are often similar to those for the valid execution of a will or other estate planning document.

Advance directives of both types are often protected by state statutes and federal regulatory policies (e.g., the Joint Commission, Centers for Medicare & Medicaid Services). However, these protections typically have notable limits, such as acceptance of good faith (albeit imperfect) implementation by providers, deference to the professional judgment of providers, and preemption by other situations commonly recognized as not requiring informed consent from the person receiving treatment (such as emergency situations). Both types of documents can be conceptualized as an individual providing informed consent in advance or through a substitute decision-maker. The goal of both types of documents is for the individual to retain a small measure of control in a situation in which they would normally not have decision-making power or ability.

However, the similarities seem to end there. Although the legal standards vary by jurisdiction, the assessment of whether an individual is unable to make healthcare decisions due to a psychiatric condition is often more nuanced than if the individual had been incapacitated by a physical health condition. Often, states require either the agreement of two providers or a court order to activate a DMHT, which can create a protracted assessment process, especially if the providers disagree. Unlike the seeming ubiquitousness of medical provider awareness of and comfort with the legal and ethical implications of healthcare advance directives, most mental health providers are not knowledgeable of and comfortable with DMHTs (Avila & Leeper, 2022; Elbogen et al., 2006; Quinlan & Coffey, 2015). While healthcare advance directives are clearly

legally recognized in every state, many states do not have clear legal status for DMHTs (National Resource Center for Psychiatric Advance Directives [NRC-PAD], 2024). Further, while most healthcare organizations have clear policies regarding the completion, filing, and implementation of healthcare advance directives, mental health providers have identified basic pragmatic issues (e.g., document location) as common barriers to the implementation of DMHTs (Van Dorn et al., 2008).

In perhaps the most striking difference, DMHTs are often approached by providers, attorneys, and judges with an apprehension seemingly absent from healthcare advance directive implementation. Although this trepidation could reasonably stem from lack of training, uncertainty regarding legal requirements, or unclear organizational policies, another theme has emerged time and time again – alarm about the content of the document itself, and specifically, the role of treatment refusal (Van Dorn et al., 2008; Applebaum, 2004; Avila, 2023). Concerns about treatment refusal in DMHTs seem most distressing to providers, especially when coupled with apprehension about their possible legal liability, possible harm to the individual with a DMHT via their "lack of insight," or possible detriment to public health and safety. Fortunately, these concerns can be robustly and independently addressed in three different ways: the available scientific literature, the existing legal authority, and the ideological foundations of DMHTs.

First, prior content analyses on DMHTs indicated the overwhelming majority contained clinically useful information and were feasible overall (91%, Swanson et al., 2006; 95%, Srebnik et al., 2005; Treichler et al., in preparation). In addition to possibly identifying a trusted substitute decision-maker or allergies, people with DMHTs often expressed preferences for treatment location, medication type and dosage, specific de-escalation strategies, or different types of care (e.g., hospitalization, respite care). Although there is exceedingly limited research currently available on the use of DMHTs in a crisis, it appears that if the existence of a DMHT is known, its conditions are respected (Backlar & McFarland, 1996). People with DMHTs are less likely to experience coercive interventions (Swanson et al., 2008), including compulsory hospital admissions (Tinland et al., 2022). Further, people with DMHTs demonstrated lower utilization of intensive healthcare services, lower healthcare costs, and higher overall quality of life (Loubiere et al., 2023). Taken together, these findings suggest that the vast majority of people who complete a DMHT are not doing so to refuse treatment; rather, they seem to be doing so to communicate important and helpful information to future providers about how to most effectively aid their recovery from an acute mental health episode.

Second, statutory schemes regarding DMHTs often have clear caveats limiting the impact of potential treatment refusals on provider liability or harm to the individual or others (Swanson et al., 2006). Using Oregon's laws as an example, providers are allowed to administer alternative treatment if the requested treatment is not available or consistent with reasonable medical practice (ORS § 127.717). They are also allowed to withdraw from providing treatment at all if unwilling or unable to enact the preferences of the individual. Additionally, providers are explicitly not subjected to criminal prosecution, civil liability, or professional disciplinary action if the DMHT is found to be invalid and they acted on it in good faith (ORS § 127.725). In emergency situations, providers may act, even in violation of the DMHT (ORS § 127.725).

There is extremely limited case law on the enforceability of a treatment refusal in a DMHT, a circumstance which itself suggests there have been limited problems on this point in the approximately forty years since the first DMHT laws were passed. In the earliest and most notorious case, *Hargrave v. Vermont* (2003), a Vermont state statute added a mechanism by which providers could, in direct violation of a DMHT, involuntarily medicate people with mental illness who were also incarcerated or civilly committed after adherence to the DMHT for 45 days did not create "significant clinical improvement" (p. 31). This mechanism had fewer procedural protections than the default mechanism for those not diagnosed with a mental illness and civilly committed or incarcerated (i.e., requiring a court hearing and the appointment of a guardian to set aside an advance directive). The Second Circuit appellate court struck down Vermont's differential treatment of people under the supervision of the state with mental health diagnoses as violating the Americans with Disabilities Act. In the opinion, among other arguments, the court applied SCOTUS's reasoning from the landmark disability rights case, *Olmstead v. L.C. ex rel. Zimring* (1999; finding discrimination on the basis of disability type, as opposed to only whether a disability was present). Of note, although the plaintiff in the case had a DMHT declining treatment, the court never reached the issue of the treatment declination itself.

In a more recent case, *In re Civil Commitment of Froehlich* (2021), the Minnesota appellate court allowed an unclear DMHT to be overridden after noting the document included some statements indicating refusal of all medication, some statements consenting only to medications selected by his substitute decision-maker, and some statements even naming specific medications he was willing to take. Notably, the court explicitly indicated that "mere disagreement with a treatment provider's recommendation 'is not evidence of an unreasonable decision'" (p. 255). In *In re AA* (2005), a New Jersey trial court found that when a substitute decision-maker identified in a DMHT consented to ECT, "the formal procedures normally mandated [under New Jersey law] prior to the administration of ECT without consent are unnecessary" because the DMHT's provisions "serve[d] as a substitute for the patient's consent at the time the ECT is administered" (p. 979). Although not directly related to court adjudication of a treatment declination in a DMHT, this case helps reinforce the idea that DMHTs are simply an individual's words or trusted decision-maker standing in to provide informed consent when the individual is incapacitated.

Finally, even if the available scientific literature and legal authority indicated that DMHT content (including treatment refusals) was a serious problem in the implementation of DMHTs, the ideological underpinnings of this intervention reveal the irrelevancy of this argument. DMHTs were first popularized in the 1980s and 1990s as part of a larger national movement to empower consumers of mental health treatment and center a recovery orientation in the treatment of mental health issues (Spaulding et al., 2014; Avila & Leeper, 2022). As DMHT laws sprung up around the country, a surge of research followed in the 2000s, which predominantly confirmed that DMHTs, when used, did exactly what they were supposed to do – they effectively communicated the treatment wishes of the people who executed them (Srebnik et al., 2005) and reduced coercive interventions (Swanson et al., 2008). Consumers reported they found it particularly meaningful to be able to proactively plan for a psychiatric crisis, to influence how they were involuntarily treated, and to be believed, even by unfamiliar providers (Amering et al.,

2005). DMHTs were wildly popular (i.e., up to 77% of people with serious mental illness (SMI) reporting a preference for one) and depressingly rare (i.e., prevalence rates as low as 4%; Swanson et al., 2006).

Although, perhaps foreseeably, DMHTs often make providers uncomfortable, they were never intended to offer security to providers or create yet another path by which people with serious mental illness could be involuntarily treated. The purpose of this shift in legal power was solely to put decision-making back in the hands of the people experiencing involuntary treatment. Interestingly, provider consternation about DMHTs in particular (as opposed to general advance directives) seems to parallel the Vermont law that was struck down as impermissible discrimination under the ADA over twenty years ago. Although it has often been said it takes seventeen years to disseminate evidence-based practice to the field (Munro & Savel, 2016; Robinson et al., 2020), this gap is particularly concerning given the intrusiveness and irreversibility of many involuntary mental health treatments.

Ultimately, providers are no more handcuffed by an individual executing a DMHT than they would be if that individual were to walk into their office, with full healthcare decisional capacity, and ask for (or decline) a particular treatment option. All the other involuntary treatment options continue to exist, as well as court proceedings for challenging legal documents, including DMHTs. A person with the capacity to make healthcare decisions should have those decisions respected, regardless of their disability status or type. To automatically treat people with SMI or their choices made while competent as inherently suspect is institutionalized discrimination. Providers lose nothing with the promotion of DMHTs; consumers could experience increases in self-determination, dignity, autonomy, and quality of life.

While DMHTs may be useful in many situations, there continue to be very real, typically pragmatic barriers to their implementation, including limitations on awareness among both providers and consumers, accessibility (e.g., where to find and store the legal form), dissemination (e.g., how to share the form once completed), transportation to preferred service locations, and funding for preferred services. Although DMHTs may have struggled to gain traction decades ago, there is a new energy behind this legal mechanism and new technology available to facilitate it. Simple and brief email interventions have been shown to increase awareness, understanding, and willingness to implement DMHTs among providers (Avila & Leeper, 2022). Researchers are currently examining how the Veterans' Administration electronic medical record may provide a model for accessibility and dissemination of DMHTs (Treichler et al., in preparation). New laws are increasingly being passed to promote the use of DMHTs in states where it was previously not explicitly allowed (e.g., Nebraska, 2023). Despite the development of new, clever, and creative approaches in this area, one old, familiar idea voiced by Frederick Douglass remains true: "Power concedes nothing without a demand. It never did and it never will."

If you want to learn whether there are DMHT-type laws in your state, visit the website for the National Resource Center on Psychiatric Advance Directives (nrc-pad.org) or your state's protection and advocacy agency (i.e., "Disability Rights [state name]" or [State name] Advocacy Center").