Implementing Psychiatric Advance Directives: Service Provider Issues and Answers

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Abstract

Psychiatric advance directives (PADs) are an emerging method for adults with serious and persistent mental illness to document treatment preferences in advance of periods of incapacity. This article presents and responds to issues most frequently raised by service providers when planning for implementation of PADs. Issues discussed include access to PADs; competency to execute PADs; the relationship of PADs to standards of care, resource availability, and involuntary treatment; roles of service providers and others in execution of PADs; timeliness and redundancy of PAD information; consumer expectations of PADs; complexity of PADs; revocation and "activation"; legal enforceability of PADs; the role and powers of agents; liability for honoring and not honoring PADs; and use of PADs to consent for release of health care information. Recommendations are made for training staff and consumers, consideration of statute development, and methods to reduce logistical, attitudinal, and system barriers to effective use of PADs.

Psychiatric advance directives (PADs) are an emerging method of treatment planning for adults with serious and persistent mental illness (SPMI). Originally conceptualized as "psychiatric wills" designed to refuse unwanted treatment, PADs may now specify both prescriptive treatment preferences and proscriptive treatment refusals. PADs are created during periods of competency to be used during future periods of compromised decision-making ability. As such, PADs are considered particularly appropriate for persons with mental illness who may have fluctuating decision-making abilities.

Instructions in PADs can include preferences about medications, electroconvulsive therapy (ECT), restraint and seclusion, hospitals, alternatives to hospitalization, persons to contact regarding care.

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The term incapacity generally refers to clinically defined periods of compromised decision-making ability. In contrast, incompetency is a legal term referring to court-determined periods in which consumers are considered to be unable to make reasoned treatment decisions. The term incapable is often used in psychiatric advance directive statutes to define the period where a consumer lacks the capacity to make mental health care decisions. These terms are often used interchangeably. In this article, we will use incompetency, except in discussion of specific statutes in which other terms are used.

of dependents and household, and consent to release treatment records. A consumer may also designate an “agent” or Durable Power of Attorney (DPOA) for health care who has legal authority to advocate for, and make treatment decisions consistent with, a consumer’s instructions in a PAD.

National consumer advocacy groups have been proponents of PADs. A number of state mental health authorities have also supported PADs through programs and trainings to facilitate their implementation. Seventeen states have developed explicit statutes to support the use of PADs. An additional 29 states implicitly allow PADs through their DPOA and Living Will Statutes.

Supporters of these efforts to recognize and expand the use of PADs believe they have significant potential to improve services and outcomes for consumers. Foremost, PADs provide a mechanism to include consumer “voice” and choice during mental health crises, when consumers are often least likely to have meaningful participation in treatment decisions. Such involvement and choice in treatment decisions can enhance treatment self-efficacy and responsibility, consumer-provider collaboration and respect, treatment adherence, and consumer outcomes. PADs can also support planned, effective crisis treatment by identifying and mobilizing resources to de-escalate crises and to serve as viable alternatives to hospitalization. These efforts may, in turn, reduce hospitalizations and associated court proceedings and costs.

Despite these potential benefits, little is known about the practical steps and issues involved in implementing and using PADs. In particular, there has been no discussion of how to respond to common issues raised by mental health service providers, and their associated administrators and risk managers, during planning for implementing PADs. The perspectives of these stakeholders are important because these individuals are most likely to encounter the documents during mental health crises. This focus is not meant to discount the views of consumers. Indeed, obtaining consumer views is the central tenet of PADs. However, the attitudes of providers toward PADs will likely impact their use and effectiveness, and whether they are honored. By anticipating and resolving provider concerns, implementation of PADs is more likely to be successful. Consequently, consumers are more likely to have their decisions respected and followed, increasing the likelihood that the concomitant benefits of PADs to consumers and service systems will be realized.

The purpose of this article is to present and respond to the issues raised most frequently by outpatient, inpatient, and crisis service staff, and their administrators. Responses from a legal and practice perspective are presented; however, it is beyond the scope of this article to present either model legislation or a comprehensive PAD implementation plan. The article also does not detail the strengths of PADs that participants discussed. However, participants were generally supportive of PADs and, in a separate survey, over three-quarters reported that PADs would be useful for consumers and treatment providers. Participants believed PADs had the potential to provide the benefits suggested in the literature if the practical and legal issues summarized below could be addressed.

Methods

Context

Meetings to educate service system stakeholders about PADs were held in 2 counties in Washington State between July 2000 and October 2001 as part of a research study focusing on implementation and impacts of PADs. Meetings were held for staff of one urban community mental health center in each county and for staff of their associated inpatient and crisis service programs.

The educational meetings introduced participants to the intent and concepts of PADs, and allowed participants an opportunity to express potential barriers to implementation of the documents so