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PSYCHIATRIC ADVANCE DIRECTIVES

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The right to personal sovereignty is arguably one of the most valued and fundamental freedoms in American society. Protections of this right for persons with disabilities are manifest throughout our legal system (i.e., the Americans With Disabilities Act of 1990, Rehabilitation Act of 1973 and the 1992 Amendments, and the Patient Self-Determination Act of 1990) and are central to the ethical principles that guide medical and research practices. However, an individual's right to self-determination is not ubiquitous. It is mediated by resources, opportunities, and law and is predicated on one's capacity to make rational, autonomous decisions (Backlar, 1995). The ethical principle of autonomy, or respect for persons, defines an *autonomous person* as one who is "capable of deliberation about personal goals and of acting under such deliberation" (National Institutes of Health, 2008). For practitioners and researchers, to respect autonomy involves giving "weight

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Person-Centered Care for Mental Illness: The Evolution of Adherence and Self-Determination,
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to the autonomous person's considered opinions and choices while refraining from obstructing his or her actions" (National Institutes of Health, 2008). Persons with mental illness, however, continue to face considerable obstacles in exercising their rights to self-determination within the parameters of these statutes.

As the focus of mental health practitioners has shifted to *recovery from mental illness* (defined as living a meaningful life, despite one's illness), it is time to leave behind vestigial assumptions of incapacity and dependency that taint our understanding and approach to treatment of persons with mental illness. People with mental illness are "first and foremost, citizens who have the right to expect that they will be treated according to the principles of law that apply to all other citizens" (National Council on Disability, 2000, p. 7). Although many may experience intermittent periods of impaired capacity, it is critical to remember that (a) decision-making capacity is neither a static trait nor a dichotomous (all or nothing) state, and (b) a person who has lost the capacity to make treatment decisions has not lost the right to do so (Dunlap, 2000).

In 2003, the Final Report of the President's New Freedom Commission on Mental Health (2003) put forth as its first recommendation that "services and treatments must be consumer and family centered [and] geared to give consumers real and meaningful choices" (p. 5). This poses particular challenges for mental health service providers, administrators, and courts: namely, how to incorporate strategies for promoting consumer self-determination into the system while ensuring that those who need access to care the most, but may not recognize it, receive it. This challenge is not insurmountable, however. In this chapter, I explore the "beneficence vs. autonomy" dilemma further in the context of psychiatric and medical treatment and present advance directives for health care decisions as a potential solution to this inherent ethical dilemma.

THE BENEFICENCE VERSUS AUTONOMY DILEMMA

Being able to distinguish between rational, autonomous decision making and impaired decision making is critical to ensure that an individual's right to self-determination is protected and respected, even if the ultimate decision is incongruent with providers' recommendations. The challenge for persons with mental illness is that it is often only when there is a discrepancy between a patient's choices and a provider's recommendations that one's ability to make rational, autonomous decisions is questioned. During these periods, the right to voluntary or self-determined choice often must be balanced with other guiding principles and legal statutes—namely, the

right to beneficence and protection from undue harm. If an individual is deemed impaired, governmental responsibilities under the doctrines of *parens patriae* (responsibility to act as a “parent” on behalf of a disabled citizen) or *police powers* (responsibility to protect each citizen from harm) may take precedence over his or her right to self-determination. Civil commitment and mandatory treatment laws can be enacted under either of these constitutional powers, depending on the nature of the concerns. Although the motive for enacting such legislation is often benevolent and may be in the “best interest” of the patient, the restriction of individual liberty and freedom that ensues carries its own harmful consequences. In the 2000 report commissioned by the President and Congress, *From Privileges to Rights: People Labeled With Psychiatric Disabilities Speak for Themselves*, the National Council on Disability concluded that the “manner in which American society treats people with psychiatric disabilities constitutes a national emergency and a national disgrace” (p. 6). This report called for the elimination of coercion, involuntary treatment, and other aversive treatments from the mental health service delivery system.

However, the professional and legal consequences of *not* intervening in a person’s best interest, particularly when restoration of capacity is expected, are often considered as dangerous as the effects of reduced self-determination for the individual. Mandatory treatment may be necessary at times to ensure that patients receive care that protects them and others from harm (Geller, 2012; Torrey & Zdanowicz, 2001). Practitioners may face liability for failing to protect clients who are not able to make decisions adequately for themselves. Some family members place great trust in the belief that their loved one will be shielded by the mental health system from making harmful decisions. The failure to do so, in the interest of self-determination, may be viewed as essentially leaving patients to “rot with their rights on” (Appelbaum & Gutheil, 1979, p. 306).

The beneficence–autonomy dilemma is not unique to psychiatry. Every physician in America has taken the Hippocratic Oath of “primum non nocere”—“first, do no harm.” Principles of informed consent and patient-centered care are considered cornerstones of medicine. Meaningful involvement of patients in medical treatment decisions is standard practice and involves not only asking patients what they want, but first providing them with accurate information about the available options and engaging with them in a process of weighing risks and benefits associated with various options and then having them decide what course of action is most consistent with their preferences, goals, and values. When a person is not physically or cognitively able to communicate his or her preferences for treatment, then physicians, family members, or courts must decide on the best course of action given the information at hand. Highly publicized court cases such

as *In re Quinlan* (1976; see Case Example 1) and *Cruzan v. Director, Missouri Department of Health* (1990; see Case Example 2) brought to public light an individual's right to choose what happens with his or her body over what others may think is best (Thomasma, 1991).

After each of these landmark court cases (presented in the case examples throughout this chapter), advance directive statutes rapidly emerged (and later changed) across the states. An *advance directive* is a written legal document in which a person specifies his or her preferences for health care or end-of-life treatment prior to a time when he or she might not be capable of communicating such preferences. Living wills, Durable Power of Attorney for Healthcare Decisions, Do Not Resuscitate orders, and wishes regarding organ donation are all examples of advance directives. Ten years after the New Jersey Supreme Court ruled in the Quinlan case, 41 states had enacted "living will" laws that recognized the written wishes of an individual regarding end-of-life treatment, made in advance, as evidence of what an individual would decide if he or she were able to communicate in the moment (Sabatino, 2010). Fourteen years later, immediately following the U.S. Supreme Court decision in the Nancy Cruzan case, Congress passed the Patient Self-Determination Act of 1990, which required all Medicaid-funded facilities to (a) inform all patients upon admission, and in writing, of their rights under state law to make health care decisions, including acceptance and refusal of treatment, and to create an advance directive; (b) create written policies regarding advance directives; (c) document in each chart whether a person has an advance directive; (d) ensure compliance with state laws; and (e) provide education about advance directives to staff and the community (Omnibus

CASE EXAMPLE 1 Karen Ann Quinlan

In 1975, 21-year-old Karen Quinlan was admitted to the hospital after friends found her unresponsive and not breathing. Neurologically, Ms. Quinlan was considered to be in a "persistent vegetative state" and was thought to be kept alive only by a ventilator and feeding tubes. After several months of watching their daughter deteriorate, with no hope for recovery, Karen's parents made the heart-wrenching decision to have the hospital remove the ventilator and let Karen die naturally. The hospital refused out of concerns that because Karen had brain activity, albeit slow and irregular, removal of the ventilator itself might be equivalent to euthanasia. The case went to the Supreme Court of New Jersey, where it was decided that in the absence of conclusive evidence of her wishes regarding life sustaining interventions, Karen's rights to privacy and choice could be "asserted on her behalf by her guardian." They concluded that "there is a real and in this case determinative distinction between the unlawful taking of the life of another and the ending of artificial life-support systems as a matter of self-determination." (*In re Quinlan*, 1976, p. 34)

CASE EXAMPLE 2

Cruzan v. Director, Missouri Department of Health

In 1990, the U.S. Supreme Court presided over the case of *Cruzan v. Director, Missouri Department of Health*. After a tragic car accident, 25-year-old Nancy Cruzan suffered severe brain injuries and was left in a “persistent vegetative state.” After being kept alive by a feeding tube for 5 years, with no hope for her recovery, Nancy’s parents requested that the hospital remove the feeding tube. The hospital required a court order, and the Missouri Supreme Court ruled against the request. The case was brought before the U.S. Supreme Court where the Missouri court’s decision was upheld on the grounds that it was not unconstitutional for Missouri to require “clear and convincing evidence” of a person’s wishes regarding life support removal, that the Due Process clause of the Constitution, which allows individuals the right to refuse medical treatment, applied to competent persons, and that Due Process did not require acceptance of “substituted judgment” in the absence of clear and convincing evidence of a person’s wishes. With additional testimony as evidence, the case was presented again before a Missouri court, which granted permission to remove Ms. Cruzan’s life support. Twelve days later and 8 years after her accident, Nancy Cruzan died.

Budget Reconciliation Act of 1990). Today, every state has some form of statute in place to protect the creation of advance directives for health care, usually under Living Wills or Durable Power of Attorney for Health Care laws, but specific legislation varies by state.

TYPES OF ADVANCE DIRECTIVES

Advance directives may be written directives that outline the type of care desired, directives that appoint a proxy decision maker (Durable Power of Attorney for Healthcare), or a combination of both. In written directives, people can indicate their preferences for things such as treating physicians, hospitals, emergency contacts, and particular treatments (including medication, electroconvulsive therapy, restraints, and seclusions). Many states have specific advance directive toolkits and forms to help guide the process. These toolkits often include space to include other descriptive information that may be helpful in providing context to the decisions outlined, such as reasons for preferring one treatment over another, past history with medications, and things that a person has found to be helpful or unhelpful in the past. Many states also require the appointment of a proxy decision maker, or Durable Power of Attorney for Healthcare, to serve as the voice for the person during times when he or she may not be able to speak for himself or herself, although this has been another challenge for many people with psychiatric disabilities who may not be able to identify a “trusted other” to assume this role.

To create an advance directive, two conditions must be met: (a) a person must be able to have the capacity to make health care decisions at the time of execution (the moment the advance directive is signed, witnessed, and notarized); and (b) a person must be able to communicate his or her preferences effectively in such a document (Fagerlin, Ditto, Hawkins, Schneider, & Smucker, 2002). The document must be explicit: If it is prepared in a haphazard manner, or if it includes contradictions and requires someone else to interpret its meaning, it may be of little assistance. Yet, being too specific in an advance directive may also contribute to its lack of utility in a crisis situation because the specific preferences outlined may not be available options. On the other hand, given the complexity of the decisions that treatment providers face on a daily basis, a directive containing simple expressions of what a person wants and rejects may not suffice in estimating preferred care. As Froberg and Kane (1989) pointed out,

[a] critical element in decision-making is determining what we value . . . choices are rarely black and white. More often than not, they involve trading one desirable (or undesirable) outcome for another. . . . Moreover, values are not static but may change over time or in response to specific experiences. (p. 356)

To maximize the likelihood that an advance directive will be followed, if and when the need arises, most states have advocacy organizations that can assist with the drafting of advance directives free of charge. Recent research also suggests that *structured facilitation*, in the form of collaborative, guided discussion between a patient and clinician or advocate, may be a particularly useful method of executing an advance directive (Swanson, Swartz, Ferron, et al., 2006). Such facilitated discussion provides an opportunity for shared decision making, joint review of prior history (when done with a clinician or other known person), and secondary input into the phrasing of preferences.

ADVANCE DIRECTIVES FOR MENTAL HEALTH TREATMENT

In 1982, Thomas Szasz proposed the creation of a “psychiatric will” that would allow a person who was mentally competent to refuse future involuntary psychiatric treatment: “Competent American adults should have a recognized right to reject involuntary psychiatric interventions that they may be deemed to require *in the future*, when they are *not competent* to make decisions concerning their own welfare” (p. 766, italics in original). Mental health crisis plans are not uncommon, and today Wellness Recovery Action Plans and person-centered treatment plans are valuable tools used in many treatment facilities.

In recent years, the Patient Self-Determination Act has been interpreted in a broader sense to cover, in a legal manner, the self-determination rights of persons with mental illness during periods of impaired decision-making capacity through the creation of psychiatric advance directives (PADs). The primary difference between PADs and other medical directives is that PADs are plans for periods of mental health crisis and are concerned with “restoration, recovery, and ongoing life,” rather than with death (Backlar, 1997). While there is typically little or no distinction between medical and psychiatric advance directives in state or federal law (both are one and the same under the Patient Self-Determination Act), the application of advance directives to psychiatric treatment does pose some unique challenges and concerns.

For some individuals, the deliberations and decisions involved in creating an advance directive may be especially difficult to make in the moment, particularly if an impairment affects psychiatric or cognitive functioning or if an illness is newly diagnosed. The process by which a person evaluates treatment options in light of individual preferences for care or outcomes is complex and for many individuals may be a totally foreign process. Moreover, many mental health practitioners have been trained in models that reinforce the “expert” role. For example, when they asked psychiatrists about the utility of shared decision making in the treatment setting, Hamann et al. (2009) found that they were in favor of such models, but only when patients were “compliant” and had “capacity” for decision making. This sort of circular reasoning poses a particular dilemma in translating shared decision-making models into mental health care—people can make their own decisions as long as they have decision-making capacity, but decision-making capacity is determined to a large extent by the quality of the decisions they make. When a poor decision is viewed in light of the person’s mental illness, he or she is likely to be seen as “symptomatic” or “sick” as opposed to just making a bad decision. It is important to remember through these deliberations that society tolerates and even respects poor choices provided that they are made by people who do not suffer from mental illness. Most persons with serious mental illnesses retain the same “right to be wrong” most of the time.

Because the application of advance directives to psychiatric treatment decisions is relatively new, “the groundswell of interest in these instruments largely precedes the development of a coherent body of governing law” (Gallagher, 1998, p. 746). Although existing state statutes provide authority for the use of advance directives in psychiatric settings, “serious questions remain regarding the scope of the enforceability, particularly in the context of involuntary treatment” (Gallagher, 1998, p. 746). To my knowledge, only one court case has tested such authority to date: *Hargrave v. Vermont* (2001). The subject of this case was Act 114, a provision in Vermont state law that allowed for mental health treatment decisions in a Durable Power of Attorney

CASE EXAMPLE 3
Hargrave v. Vermont, 2001

Nancy Hargrave, a Vermont resident diagnosed with schizophrenia, had been hospitalized multiple times since 1995 in the Vermont State Hospital. Twice while hospitalized in 1997, Ms. Hargrave was the subject of involuntary medication hearings. In the first hearing she was found competent to refuse medication, but in the second hearing she was found incompetent to refuse medication and was administered psychiatric medication over her objection in a nonemergency situation. On April 14, 1999, Ms. Hargrave executed a DPOA [Durable Power of Attorney for Healthcare Decisions] designating a guardian and refusing all psychotropic medications. On April 27, 1999, Ms. Hargrave filed suit arguing that even though she was competent at the time when she executed her DPOA, it could be overturned via Act 114 solely on the basis of her mental illness. The federal Magistrate judge ruled that

Act 114 is facially discriminatory against mentally disabled individuals insofar as it allows their lawfully executed DPOAs to be abrogated when they have been determined to be “in need of treatment”—in other words, when they have been found to be incompetent to make their own health care decisions. No such provision in the law similarly subject non-mentally disabled individuals to abrogation of their lawfully executed DPOAs, even where honoring their wishes might result in their death. (*Hargrave v. Vermont, 2001*, p. 28)

for Healthcare Decisions to be overridden if a person was diagnosed with a psychiatric disability, was civilly committed, and doctors felt that the treatment decisions outlined in the Durable Power of Attorney for Healthcare Decisions were not resulting in improvement. A federal Magistrate judge ruled that Act 114 violated the Americans With Disabilities Act because it explicitly deprived persons with mental illness of the same rights as people without mental illness (*Hargrave v. Vermont, 2001*; see Case Example 3).

RESEARCH ON PSYCHIATRIC ADVANCE DIRECTIVES

Research on PADs and medical directives suggests that although a large majority of people state an interest in completing an advance directive and articulate the value of doing so, a very small minority of people actually complete the directives to execution. Despite the overwhelming interest in such documents, recent studies have shown that only approximately 7% of people with mental illness have executed such a document (Swanson, Swartz, Ferron, Elbogen, & Van Dorn, 2006). Although the prevalence of advance directives among the general population is higher than among persons using mental health services, it is still alarmingly low (between 17% and 35%).

Backlar and McFarland (1996) surveyed relatives and mental health providers about the completion of a PAD by any of their clients or relatives. They found that out of the 23 family members and the 133 providers who responded, 64 advance directives had been completed by their clients or loved ones. In these directives, 40 consumers had identified a proxy decision maker and 10 consumers had used the advance directive in times of crisis. In each case the consumer's wishes had been honored. In terms of content, very few of the consumers who had completed an advance directive indicated a preference for no treatment at all.

A second study in 2001 followed 30 people who created a PAD over an 8- to 10-month period. At follow-up, the researchers found that although most of the consumers were still satisfied with the PAD, they believed that the providers themselves did not have adequate information about the documents. Three of the four consumers with a PAD had been hospitalized between the interviews (one was hospitalized twice). In all but one of the four hospitalizations, the PAD was ignored. The authors concluded that "a legal change—although necessary—is an insufficient step to engender social or political change" (Backlar, McFarland, Swanson, & Mahler, 2001, p. 437).

Geller (2000) investigated the use of health care proxies in making decisions regarding psychiatric interventions in a Massachusetts state hospital. The investigator examined the charts of all patients in the psychiatric hospital for the presence of an advance directive. Out of 161 patients in the hospital at the time of the chart review, 71 had full guardians and thus were not eligible to execute an advance directive. Of the remaining 90 patients, 53 had health care proxies in their chart; however, 34 patients had refused to sign them. Thus, only 16 patients (10%) had meaningful proxies in their charts. The author further examined the commitment status (whether they were voluntary, civilly, or criminally committed) of the 37 patients without health care proxies and determined that of the 161 patients at the hospital, a maximum of 40 (25%) were "even in a position to potentially have a health care proxy that could have meaningfully affected their inpatient status" (Geller, 2000, p. 10).

In a recent randomized controlled trial, 469 persons with serious mental illness were randomly assigned to one of two groups: (a) facilitated PADs or (b) a control group receiving only PAD information and referral for assistance (Swanson, Swartz, Elbogen, et al., 2006). Investigators found that 63% of persons in the facilitated PAD condition, compared with only 3% in the control group, executed an advance directive. Out of the 158 individuals who executed an advance directive (facilitated PAD and control combined), not a single person used the PAD to refuse treatment altogether. At 1-month follow-up, persons in the facilitated PAD group reported a greater working alliance and were more likely to report receiving the treatment they needed,

regardless of whether a PAD was executed. At 6-, 12-, and 24-month follow-up, persons who completed a PAD were less likely to experience a coercive intervention than those who did not complete a PAD (Swanson et al., 2008).

BARRIERS AND CONCERNS

Several stakeholder opinion surveys highlight potential barriers to the successful implementation of advance directives in psychiatry. A first major barrier is the lack of information that consumers, mental health professionals, families, and other community members have about the application of advance directives to mental health treatment (O'Connell & Stein, 2005; Scheyett, 2008; Shields, Pathare, van der Ham, & Bunders, 2014). Treatment providers have expressed concerns about issues such as potential legal ramifications associated with the documents, the determination of decision-making capacity, and logistical issues around the implementation of psychiatric advance directives (Mezey, Teresi, Ramsey, Mitty, & Bobrowitz, 2000; O'Connell & Stein, 2005; Srebnik, Appelbaum, & Russo, 2004; Srebnik & Brodoff, 2003; Srebnik & Kim, 2006). Mental health consumers have expressed concerns that patients might experience an increased sense of loss of control and distrust if their directives were not honored (Backlar & McFarland, 1996) and fears that the documents may be used as a way of validating involuntary treatment (Geller, 2000; Sales, 1993). Despite the potential benefits associated with the documents, understanding and addressing some of the misconceptions or concerns of various stakeholder groups about PADs may be a critical link to the successful use of these documents (O'Connell & Stein, 2005).

CONCLUSION

Over the past few decades, the definition of recovery from mental illness has evolved from a return to premorbid functioning or a remission of symptoms to one that incorporates finding purpose and meaning in life, regaining citizenship, and having valued roles, despite one's ailments or disability (Davidson et al., 2001; Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Davidson & Strauss, 1992; Davidson, Tondora, & Ridgway, 2010; Davidson & White, 2007). Offering people with serious mental illnesses opportunities for choice and self-determination is considered a critical component of recovery-oriented care. More than that, it also is an essential element of delivering care that is responsive to an individual's needs,

desires, and values. An emerging body of research suggests that incorporating elements of choice and self-determination into care may also enhance treatment engagement and outcomes (see Davidson et al., 2012, for a review). Yet, the practical and ethical mechanisms for doing so are challenging, as noted here. Advance planning tools, such as advance directives, may serve as important vehicles to protect not only the rights of individuals in treatment but also those of the providers who may be “responsible” for their care.

REFERENCES

- Americans With Disabilities Act of 1990, 42 U.S.C.A. § 12101-12213 *et seq.*
- Appelbaum, P. S., & Gutheil, T. G. (1979). “Rotting with their rights on”: Constitutional theory and clinical reality in drug refusal by psychiatric patients. *Journal of the American Academy of Psychiatry and the Law Online*, 7, 306–315.
- Backlar, P. (1995). The longing for order: Oregon’s medical advance directive for mental health treatment. *Community Mental Health Journal*, 31, 103–108. <http://dx.doi.org/10.1007/BF02188759>
- Backlar, P. (1997). Anticipatory planning for psychiatric treatment is not quite the same as planning for end-of-life care. *Community Mental Health Journal*, 33, 261–268. <http://dx.doi.org/10.1023/A:1025038922626>
- Backlar, P., & McFarland, B. H. (1996). A survey on use of advance directives for mental health treatment in Oregon. *Psychiatric Services*, 47, 1387–1389.
- Backlar, P., McFarland, B. H., Swanson, J. W., & Mahler, J. (2001). Consumer, provider, and informal caregiver opinions on psychiatric advance directives. *Administration and Policy in Mental Health*, 28, 427–441. <http://dx.doi.org/10.1023/A:1012214807933>
- Cruzan v. Director, Missouri Department of Health, 497 U.S.261, 110 S. Ct. 2841, 111 L. Ed. 2d 224 (1990).
- Davidson, L., O’Connell, M. J., Staeheli, M., Weingarten, R., Tondora, J., & Evans, A. C. (2001). *Concepts of recovery in behavioral health: History, review of the evidence, and critique*. New Haven, CT: Yale University School of Medicine, Department of Psychiatry.
- Davidson, L., O’Connell, M. J., Tondora, J., Lawless, M., & Evans, A. C. (2005). Recovery in serious mental illness: A new wine or just a new bottle? *Professional Psychology: Research and Practice*, 36, 480–487. <http://dx.doi.org/10.1037/0735-7028.36.5.480>
- Davidson, L., Roe, D., Stern, E., Zisman-Ilani, Y., O’Connell, M., & Corrigan, P. (2012). If I choose it, am I more likely to use it? *International Journal of Person Centered Medicine*, 2, 577–592.

- Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, *65*, 131–145. <http://dx.doi.org/10.1111/j.2044-8341.1992.tb01693.x>
- Davidson, L., Tondora, J., & Ridgway, P. (2010). Life is not an outcome: Reflections on recovery as an outcome and as a process. *American Journal of Psychiatric Rehabilitation*, *13*(1), 1–8. <http://dx.doi.org/10.1080/15487760903489226>
- Davidson, L., & White, W. (2007). The concept of recovery as an organizing principle for integrating mental health and addiction services. *The Journal of Behavioral Health Services & Research*, *34*, 109–120. <http://dx.doi.org/10.1007/s11414-007-9053-7>
- Dunlap, J. A. (2000). Mental health advance directives: Having one's say? *Kentucky Law Journal*, *89*, 327–386.
- Fagerlin, A., Ditto, P. H., Hawkins, N. A., Schneider, C. E., & Smucker, W. D. (2002). The use of advance directives in end-of-life decision making: Problems and possibilities. *American Behavioral Scientist*, *46*, 268–283. <http://dx.doi.org/10.1177/000276402236678>
- Froberg, D. G., & Kane, R. L. (1989). Methodology for measuring health-state preferences—II: Scaling methods. *Journal of Clinical Epidemiology*, *42*, 459–471. [http://dx.doi.org/10.1016/0895-4356\(89\)90136-4](http://dx.doi.org/10.1016/0895-4356(89)90136-4)
- Gallagher, E. M. (1998). Advance directives for psychiatric care: A theoretical and practical overview for legal professionals. *Psychology, Public Policy, and Law*, *4*, 746–787. <http://dx.doi.org/10.1037/1076-8971.4.3.746>
- Geller, J. L. (2000). The use of advance directives by persons with serious mental illness for psychiatric treatment. *Psychiatric Quarterly*, *71*(1), 1–13. <http://dx.doi.org/10.1023/A:1004660915824>
- Geller, J. L. (2012). Patient-centered, recovery-oriented psychiatric care and treatment are not always voluntary. *Psychiatric Services*, *63*, 493–495. <http://dx.doi.org/10.1176/appi.ps.201100503>
- Hamann, J., Mendel, R., Cohen, R., Heres, S., Ziegler, M., Bühner, M., & Kissling, W. (2009). Psychiatrists' use of shared decision making in the treatment of schizophrenia: Patient characteristics and decision topics. *Psychiatric Services*, *60*, 1107–1112. <http://dx.doi.org/10.1176/ps.2009.60.8.1107>
- Hargrave v. Vermont, No. 2:99-CV-129 (D. Vt. Oct 11, 2001).
- In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).
- Mezey, M., Teresi, J., Ramsey, G., Mitty, E., & Bobrowitz, T. (2000). Decision-making capacity to execute a health care proxy: Development and testing of guidelines. *Journal of the American Geriatrics Society*, *48*, 179–187.
- National Council on Disability. (2000). *From privileges to rights: People labeled with psychiatric disabilities speak for themselves*. Washington, DC: Author.
- National Institutes of Health. (2008). *Protecting human research participants*. Retrieved from <https://phrp.nihtraining.com>

- O'Connell, M. J., & Stein, C. H. (2005). Psychiatric advance directives: Perspectives of community stakeholders. *Administration and Policy in Mental Health, 32*, 241–265. <http://dx.doi.org/10.1007/s10488-004-0843-4>
- Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508 (1990).
- Patient Self-Determination Act of 1990, Pub. L. No. 101-508, §§ 4206(a), 4751(m), 104 Stat. 1388-116, 1388-205 (1990).
- President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America* (Final Report 2003). Rockville, MD: Department of Health and Human Services.
- Rehabilitation Act of 1973, Pub. L. No. 93-112, 87 Stat. 355 (1973).
- Rehabilitation Act Amendments of 1992, Pub. L. No. 102-569, §§ H.R. 5482 (1992).
- Sabatino, C. P. (2010). The evolution of health care advance planning law and policy. *The Milbank Quarterly, 88*, 211–239. <http://dx.doi.org/10.1111/j.1468-0009.2010.00596.x>
- Sales, G. N. (1993). The health care proxy for mental illness: Can it work and should we want it to? *Bulletin of the American Academy of Psychiatry and the Law, 21*, 161–179.
- Scheyett, A. (2008). Psychiatric advance directives: Benefits and barriers. *Current Psychiatry Reviews, 4*, 137–144. <http://dx.doi.org/10.2174/157340008785829940>
- Shields, L. S., Pathare, S., van der Ham, A. J., & Bunders, J. (2014). A review of barriers to using psychiatric advance directives in clinical practice. *Administration and Policy in Mental Health and Mental Health Services Research, 41*, 753–766.
- Srebnik, D., Appelbaum, P. S., & Russo, J. (2004). Assessing competence to complete psychiatric advance directives with the competence assessment tool for psychiatric advance directives. *Comprehensive Psychiatry, 45*, 239–245. <http://dx.doi.org/10.1016/j.comppsy.2004.03.004>
- Srebnik, D., & Brodoff, L. (2003). Implementing psychiatric advance directives: Service provider issues and answers. *The Journal of Behavioral Health Services & Research, 30*, 253–268. <http://dx.doi.org/10.1007/BF02287316>
- Srebnik, D. S., & Kim, S. Y. (2006). Competency for creation, use, and revocation of psychiatric advance directives. *Journal of the American Academy of Psychiatry and the Law, 34*, 501–510.
- Swanson, J. W., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Ferron, J., Wagner, H. R., . . . Kim, M. (2006). Facilitated psychiatric advance directives: A randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. *The American Journal of Psychiatry, 163*, 1943–1951. <http://dx.doi.org/10.1176/ajp.2006.163.11.1943>
- Swanson, J. W., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Wagner, H. R., Moser, L. A., . . . Gilbert, A. R. (2008). Psychiatric advance directives and reduction of coercive crisis interventions. *Journal of Mental Health, 17*, 255–267. <http://dx.doi.org/10.1080/09638230802052195>

- Swanson, J., Swartz, M., Ferron, J., Elbogen, E., & Van Dorn, R. (2006). Psychiatric advance directives among public mental health consumers in five U.S. cities: Prevalence, demand, and correlates. *Journal of the American Academy of Psychiatry and the Law*, *34*, 43–57.
- Szasz, T. S. (1982). The psychiatric will. A new mechanism for protecting persons against “psychosis” and psychiatry. *American Psychologist*, *37*, 762–770. <http://dx.doi.org/10.1037/0003-066X.37.7.762>
- Thomasma, D. C. (1991). The Cruzan decision and medical practice. *Archives of Internal Medicine*, *151*, 853–854. <http://dx.doi.org/10.1001/archinte.1991.00400050007001>
- Torrey, E. F., & Zdanowicz, M. (2001). Outpatient commitment: What, why, and for whom. *Psychiatric Services*, *52*, 337–341. <http://dx.doi.org/10.1176/appi.ps.52.3.337>