

## **The Longing for Order: Oregon's Medical Advance Directive for Mental Health Treatment**

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The sirenes—half women, half birds endowed with enchanting song—lived on an island near Scylla and Charibdis. Sailors were lured to the island by their charmed singing. Once there, the seafarers would forget everything in their past and die, the songs literally stealing their lives away. Odysseus (also known by his Roman name, Ulysses), who had to sail past this place, was forewarned about these creatures who seductively promised men knowledge, but brought about their death. He instructed his crew to fill their ears with wax. However, he desired to hear the enchanted song and ordered his sailors to tie him to the mast. The verses were even more enthralling than the melody, the promise of wisdom and a “quickenning of the spirit” made Odysseus’ heart throb with yearning, but his bonds held and the danger was safely averted.

Odysseus, forewarned of future dangers, planned ahead and successfully controlled his impulsive desires. He was lucky, our attempts to regulate our lives do not always meet with such mastery.

Our human longing for order (Nussbaum, 1989) is epitomized in our interest in medical advance directives and exemplified in the 1991 implementation of the Patient Self-Determination Act (Omnibus Reconciliation Act, 1990), which requires all health care institutions

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receiving federal funds to advise newly admitted patients of their rights under state law to prepare advance directives (Appelbaum, 1991; Greco et al., 1991). Oregon's 1993 advance declaration for mental health treatment further typifies our human efforts to control our lives and make them reliably good (Nussbaum, 1986). The *Guide to Oregon's Declaration for Mental Health Treatment* (Backlar et al., 1994) is entitled "Can I Plan Now for the Mental Health Treatment I Would Want if I Were in Crisis?" At first glance, the answer to the question may be a resounding "yes," but a second careful analysis may alter that "yes" into a slightly more equivocal response.

In 1993 the 67th Oregon Legislative Assembly enacted Senate Bill 859, which created provisions for a declaration for mental health treatment. The legal document, the Declaration for Mental Health Treatment, is an advance directive that provides for consent to *or* refusal of mental health treatment at a future time when a person may lack capacity to make such decisions. In addition, the directive also permits the appointment of a surrogate decision-maker who must agree to act in a way consistent with the incapacitated person's previously stated competently-made desires.

Contracts made in advance for or against psychiatric treatment have been discussed and disputed for many years (Appelbaum, 1991). There are ideological challenges to involuntary psychiatric treatment supporting the proposal of a "psychiatric will" (Szasz, 1982) that would provide a competent person with a legal method to refuse such treatment should she or he lose capacity for refusal. And on the other hand, there are suggestions for prior agreements, which arrange for consent in advance (Rosenson & Kasten, 1991); these previously made arrangements are sometimes alluded to as Ulysses contracts (see above, Odysseus, aka Ulysses, and the Sirenes), inasmuch that the competent person binds herself or himself to future treatment (Dresser, 1984). Middle ground proposals (Rogers & Centifanti, 1991) offer choice, providing for both acceptance and rejection of psychiatric treatment. Furthermore, there are procedures that enable a competent person to appoint a representative to make medical and psychiatric determinations should she or he lose decision-making capacity (President's Commission, 1983; Omnibus Reconciliation Act, 1990; New York Law, 1991).

The Oregon Advance Directive for Mental Health Treatment allows a competent person to plan for a time when she or he may lose her or his decision-making capacity. The competent person may make specific choices for or against psychoactive medications and electro-convulsive

treatment and delineate further conditions or limitations; she or he may give or withhold consent to being kept in a health care facility (up to 17 days) for mental health treatment; and, additionally, she or he may name an adult (and an alternate) who—as the principal’s representative—will be responsible to speak for, and precisely follow, her or his mental health treatment wishes should the principal lose capacity to make such decisions (the named adult must *agree* to be a representative and indicate so by signing the legal form). The document is validated by the signatures of two witnesses who aver that they believe the person to be mentally competent at the time that the form is signed. In order to protect against the possibility of coercive pressure, certain people may not act as a representative (i.e. a principal’s providers, or owners of a treatment facility in which the principal is a patient or resident, their relatives, or their employees—unless they are related by blood, marriage, or adoption to the principal). The same limitations hold for the witnesses with the additional constraint that they may not be related to the principal.

Can such a document benefit consumers, families, community mental health providers, and the community at large? In optimum circumstances, when a person with a severe and persistent mental disorder has the *capacity to understand* factual treatment information and can discuss this over a period of time *collaboratively* with her or his provider (Katz, 1984; Appelbaum et al., 1987, Lacro et al., 1994) and a knowledgeable family member (if such a person is available), the practical use of such a declaration may be invaluable to all the participants. Such an “informed consent/refusal” dialogue can afford many values: the consumer has the opportunity for an authentically informed *choice*; the healthcare professional has the opportunity to *listen* carefully to the consumer and to provide information with clarity and precision at an unhurried pace; the family member, who may bear the difficult burden of care when the consumer is in crisis, has the opportunity to participate fully in the consumer’s treatment decisions; and furthermore, should the consumer designate a surrogate decision maker there can be considerable gain for the community both procedurally and financially (i.e. healthcare decisions can be made expeditiously; court proceedings are made unnecessary; and needs for a legal guardian may be obviated) (Herr & Hopkins, 1994; The English Law Commission, 1991).

However, the very benefits that the document may effect can also be turned into disadvantages. First, we have no way of ensuring a person’s competence at the time that she or he makes out the document. The two witnesses, whose signatures are meant to assure us that the person who

has completed the advance directive has capacity, have not themselves been vetted and may not understand how to assess the document signatory's competence to make such mental health treatment decisions. Even though this may be standard witness procedure in the making of wills and general medical advance directives, in the case of persons making consequential decisions about mental health care, it may be advisable to put in place protections to ensure that they have the capacity to participate in a truly informed consent/refusal dialogue.

We have long recognized the importance of assessing a person's capacity to accept or refuse medical care; the President's Commission on Ethical Problems in Medicine (1982) advised healthcare providers to develop clear procedures to assess patients' incapacity (Appelbaum & Grisso, 1988). Capacity to understand and appreciate the consequences of medical treatment is at the heart of the informed consent doctrine; without capacity to understand the "task at hand" (Culver & Gert, 1982) there can be no informed consent/refusal (Appelbaum et al., 1987). The witnesses' signatures on this form neither corroborates—even if the person has capacity—that authentic informed consent/refusal actually occurred, nor substantiates a person's capacity to make adequate medical treatment decisions.

There may be a basic flaw endemic to all advance medical directives, inasmuch that our competent desires may change radically when we have lost our decision-making capacity; what we wish for when we are in one state may no longer be what we want or *require* when we are in an altered state. The values and interests of a competent person may have changed fundamentally when the same person becomes incompetent. A competent person's previously stated wishes (made with certainty) could be privileged over the now incompetent person's needs (Robertson, 1991). The Oregon Advance Directive for Mental Health Treatment provides for such contingencies but in doing so may undermine the consumer's confidence in the document. Whether or not a person has signed the declaration form, if she or he is on an emergency psychiatric hold, or has been committed by a court, a physician, under strict legal guidelines, may still prescribe medicine that does not comply with the consumer's wishes. This safeguard for the decompensated consumer who has used the document in order to block all medications, nevertheless makes the document considerably less evenhanded than it purports to present itself at first glance.

If consumers, families, and community mental health providers can take the time to work cooperatively with each other and prepare these directives with the caution that is required the benefits are profound:

the consumer may be able to make informed and voluntary mental health decisions by fully participating in a dialogue with her or his mental health provider and family, consequently involuntary commitments and many hospitalizations may be avoided. On the other hand if the documents are prepared precipitously, the disadvantages may be significant: when capacity to make out such a document is ignored, consumer confidence is eroded, and the essential informed consent/refusal procedure is trivialized.

With even a minimum of reflection, we are aware that much of our human existence is driven by luck: our biology dictates our capacities and temperament; and our circumstances—who our parents are, where we are born—delineates the kinds of dilemmas we may face (Nagel, 1979). Our longing for order, it seems to me, is simply our desire to be as self-sufficient as possible in a contingent world. A reliable life may be even more important for people who suffer from severe and persistent mental disorders and who appear to experience a still more excessively chaotic and provisional world. If Oregon's Declaration for Mental Health Treatment, albeit with its drawbacks, can offer even a modicum of self-rule for consumers and enhance the quality of their lives, I, for one, count it valuable.

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