(In)voluntary Psychiatric Treatment of Geriatric Patients with Dementia: Review of Relevant State Legislation, Policy and Practice Implications

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April 5, 2011
Learning objectives:

- Describe the context and intent of recent legislation expanding authority of Healthcare Powers of Attorney regarding involuntary psychiatric treatment

- List three legal and three clinical implications of the new statute

- Discuss the ethical framework around the issue of surrogate decision-making and describe how it applies to the participant’s own practice
During our talk today…

To help you achieve these objectives, we will cover the following ground:

- We will identify the treatment population of interest,
- The questions that arise in the treatment of this population,
- Review the use of proxy decision-makers and models for proxy decision making for psychiatric care,
- And discuss Senate Bill 16 and it’s implications.
Dementia: At the interface of medicine and psychiatry

- With the aging of the US population, dementia is becoming increasingly common in our communities and in our practice settings.

- As “Baby Boomers” age, the Alzheimer’s Association predicts that the number of Oregonians with dementia will increase:
  - 33% between 2000 and 2010
  - 58% between 2000 and 2020
  - 93% between 2000 and 2025.
Dementias are complex medical syndromes with characteristic underlying pathophysiological mechanisms, but are somewhat unpredictable with regards to their psychiatric and behavioral manifestations.

However, 40-90% of patients will develop such symptoms at some point during their journey with these illnesses and these symptoms have enormous impact on patient quality of life, caregivers and the settings in which these patients reside.

This contributes to variability in the settings and treating specialists involved in the care of these patients.
Management of patients with dementia is considered within the scope of medicine and neurology practice.

However, expertise in the treatment of the more problematic behavioral symptoms or psychiatric manifestations is often lacking.

Psychiatry may seem a natural realm for addressing these aspects of dementing illness, but psychiatric care is historically bound by legal and ethical principles which make treatment of these patients challenging!
Dementia: Questions for the healthcare system

So, when patients with dementia exhibit psychiatric or problematic behavioral symptoms:

- Where do these patients go for treatment?
- What if a patient lacks insight or otherwise refuses treatment?
- How can the patients’ own preferences be best represented and effectively enforced?
Until recently these patients have been treated in emergency departments and other urgent care settings, only to be quickly returned home after “ruling out” for acute medical illness, rarely with treatments that have an impact on behaviors over time.

If psychiatric or behavioral symptoms emerge in acute or long-term medical settings, these patients are often diverted or discharged due to intense regulatory scrutiny of peer/staff safety.

And if directed towards psychiatric settings, there have been significant barriers to achieving admission and sufficient duration of treatment for these patients.
Advocates for more direct and sustained access to psychiatric treatment for these patients have argued that there are legitimate indications for short-term psychiatric stabilization including:

- Prominent behavioral disturbances such as self-harm, agitation and aggressiveness.
- And, behaviors requiring safeguards not found in medical, residential, or home settings.

Short-term hospitalization could result in improved quality of life for these patients, result in decreased patient anxiety and agitation, and allow for development of behavioral support plans and safe return to less restrictive environments.
Proxy Decision Making

But what if the patient says “NO” to psychiatric treatment?

- A patient’s right to self-determination in treatment is an overriding principle in medical ethics.

- Patient self-determination is addressed through the framework of informed consent and related concepts of mental capacity and best interests.

- When decisional capacity is limited, the need for a proxy becomes apparent.

- Proxy decision makers may include legal guardians, healthcare power of attorneys (HCPOA), family members, medical personnel and others, amongst whom prioritization is determined via legislative policy.
Protection of Vulnerable Populations: Advance Directives

- Advance Directives (ADs) link the concepts of self-determination with proxy decision-making.

- Advance Directives are derived from “right-to-die” cases seeking to safeguard patient autonomy and self determination in the case of future patient incompetency.

- They emerged from the Patient Self-Determination Act (PSDA): 1990 federal legislation that requires providers to inform all adult patients about their rights to accept or refuse medical or surgical treatment and the right to execute an “advance directive”.
Healthcare Advance Directive

In Oregon, ORS 127.505-127.660, AD form under ORS 127.531:

- The patient executing an AD, known as the principal, is presumed to be of “sound mind”.
- The principal can indicate treatment preferences, designate a HCPOA, determine his/her authority, stipulate (or not) expiration date of the AD.
- ADs are binding and enforceable at, and only at, times of patient incompetency or inability to communicate wishes.
- Objections to the AD can be made through defined procedures outlined in AD legislation.
- A capable principal can revoke AD and HCPOA designation at anytime, and revoke life-sustaining treatments as long as wishes can be communicated to HCPOA or medical provider, irrespective of capacity.
Advance Directives and mental health treatment

- The scope of ADs, however, vary state by state
- Prior to 2009, Oregon limited the health care representative’s authority to consent to the following treatments (ORS 125.540):
  1) Admission to or retention in a health care facility for care or treatment of mental illness
  2) Convulsive treatment
  3) Psychosurgery
  4) Sterilization
  5) Abortion
- Thus, ADs did not allow for psychiatric care via proxy decision maker.
Psychiatric Advance Directives

- In 1993, Oregon passed the Declaration for Mental Health Treatment allowing individuals to provide written directive and designate proxy decision makers to carry out preferences pertaining to:
  - convulsive treatment
  - treatment of mental illness with psychoactive medication
  - admission to and retention in a health care facility for a period not to exceed 17 days for care or treatment of mental illness
  - outpatient mental health services

- By 2003, 17 states developed explicit statutes supporting the use of “psychiatric advance directives” (PAD). (Srebnik and Brodoff, 2003)

- Differences exist in advance statement accessibility, production, implementation, legal enforceability, and compatibility with involuntary treatment across US and Europe (Henderson et al, 2008)
Declaration for Mental Health Treatment (ORS 127.700-127.737)

To Execute:
- Principal must be of sound mind
- Principal may designate proxy decision maker
- Two competent adults witnesses must countersign and attest that the principal was not under duress, influence, or engaged in fraud

To Operationalize:
- Declaration remain in effect for 3 years or until revoked by principal
- Takes effect when the principal has been found to be incapable
  - "Ulysses Clause" prohibits principal from revoking the document while incapacitated
- Proxy decision maker must carry out written instructions of the principal
  - if preferences unknown, the proxy acts in the best interest of the principal.

To Override:
- If principal is committed to the Oregon Health Authority
- If there is immediate danger to life or health of self or others
- Providers not bound to carry out treatment plan if sufficiently diverges from practice standards
Psychiatric Advance Directives in Theory

### Benefits of Effective Use of PADs
- consumer/family empowerment
- enhance informed decision-making
- ameliorate interpersonal/clinical relationships
- focus on prevention
- reduce hospitalization and need for commitment/guardianship

### Obstacles to Effective Use of PADs
- capacity to execute document finding appropriate representatives
- PADs not recognized or overridden
- conversely, PADs irrevocable during acute illness
- PADs not guarantee preferred treatment
- Limited awareness and access to PADs
- Lacking enforcement/monitoring of PADs
- Stigma

(Backlar and McFarland, 1998)
Psychiatric Advance Directives in Practice: Access and Implementation

PAD access and implementation:

- Preliminary Oregon survey (Backlar and McFarland, 1996):
  - N=156 family members and providers
  - 64 facilitated completed PADs, 10 PADs operationalized
  - Barriers: limited understanding of PAD laws, problematic dissemination and implementation

- Survey of public sector psychiatric outpatients in 5 US cities (Swanson et al, 2006):
  - N= 1,011 from California, Florida, Illinois, Massachusetts, and North Carolina
  - Only 4-13% completed PADs while 66-77% expressed interest in completing PADs
  - Demand positively correlated with a marginalized demographic and experience of decreased personal autonomy
  - Actual completion positively correlated with higher insight, access to social supports, and external treatment pressures
  - Potential barriers: lack of awareness/understanding of PAD laws, limited capacity and support to complete process, institutional noncompliance with PAD, limited systemic education/enforcement/monitoring of PADs
Psychiatric Advance Directives in Practice: Controversies

Should there be formal capacity assessment as part of completing PAD?
- Evaluation of 80 SPMI patients with high utilization show adequate decision-making capacity (Srebnik and Appelbaum, 2004)
- Capacity assessment may be viewed as discriminatory and barrier to completion of PAD but is warranted in cases of high clinical suspicion, preexisting doubts (Srebnik and Kim, 2006)

When should PADs be activated?
- Most states link activation of PADs to clinical standards for determining incapacity
- “Tailored Activation” - individualized criteria for incapacity determining activation of PAD
- Difficulty arises in determining whether PADs may be enforced in a voluntary treatment setting
- What if client’s current wishes of patient diverges from PAD? (Srebnik and Kim, 2006)

Right to Refuse Treatment vs Duty to Treat, or when can PADs be revoked or overridden?
- Most states prohibit revocation of PAD if client is currently incapacitated
- Most states are silent on how to enforce PAD if client is incapable of revoking but is refusing treatment
- Providers may not honor PAD if there is significant divergence from clinical practice standards (Srebnik and Brodoff, 2003)
- Hargrave. Vermont 2003 - established precedent of committed patient to refuse all treatment based on competently executed PAD
- Autonomy vs state police and parens patriae powers - Committable but untreatable patients? (Swanson et al, 2006, Miller, 1998)
So what about patients with dementia and behavioral disturbance in Oregon?

So we see:

- AD and PAD statutes are in many ways imperfect in addressing this patient population.
- What has been the practice when psychiatric hospitalization has been sought?
- Mental health providers have utilized the tools they are most familiar with:
  - The Notice of Mental Illness, found in state involuntary treatment statutes, has routinely been employed when admitting patients with dementia related behavioral disturbances who do not have capacity to provide informed consent or refuse consent for acute psychiatric care.
Evolution of Involuntary Treatment Law in Oregon

Involuntary treatment law has evolved in Oregon over the last two centuries:

- In 1862, the first commitment standard was established allowing a county judge to order hospitalization for those “by reason of insanity...is suffering from neglect, exposure or otherwise, or is unsafe to be at large, or is suffering under mental derangement”.

- Over time, statute evolved to increase the levels of civil rights protection for those with mental illness such that in 1973, commitment statutes emerged that closely resemble what is utilized in Oregon today, with the following definition:

  - A mentally ill person is a person who, because of a mental disorder, is either dangerous to himself or others or is unable to provide for his basic personal needs and is not receiving care that is necessary for his health or safety. (Bloom, Am Acad Psychiatry Law 32:430–9, 2004)
Are Involuntary Treatment Statutes applicable to Dementia?

- However, there are two aspects of involuntary treatment under commitment statutes in Oregon that make it difficult to apply these laws to those with dementing illness and behavioral disturbance:

- Commitment court trends reflect “increasing focus on dangerousness as the principle standard for which commitment is pursued”, those “gravely disabled” by their illnesses are often neglected in practice. (Bloom, Am Acad Psychiatry Law 32:430–9, 2004)

- Further, the commitment period of 180 days for treatment presumes the clinical possibility of reversing or ameliorating the illness prompting commitment.

- Thus, rarely does a patient with dementia end up referred to a commitment hearing.
Guardianship

The alternative to commitment has been to have family members seek guardianship:

- **PROS**: Guardianship allows an avenue for obtaining informed consent for treatment in psychiatric settings and for eventual placement in appropriate chronic care settings.

- **CONS**: Even when obtained as a “temporary” or “emergency” measure, guardianship takes time to secure (a minimum typically of 7-14 days), is expensive, and often requires release of medically supporting evidence.
Where we stood in 2009...

So, to recap, in Oregon prior to 2009:

- AD statutes limited HCPOA from consenting to psychiatric treatment for the principals with dementia and behavioral disturbance.

- PADs were underutilized and rarely honored, and hence, impractical for the growing population of patients with dementia.

- Commitment statutes were being applied to only a subset of these patients (those overtly aggressive or dangerous) and by a subset of counties.

- And, guardianship was costly and neither timely enough or practical enough for families to secure needed emergent treatment.
The Birth of SB 16
Geriatric psychiatrist Maureen C. Nash, MD, MS, who practices at Tuality Medical Center, was seeing increasing numbers of older adults being referred for psychiatric hospitalization due to dementia and behavior disturbances who had signed advance directives but were still being required to go through the mental health involuntary commitment process or the temporary guardianship process in order to be admitted to psychiatric facilities for treatment and stabilization.

She requested amendment to AD statutes through the Senate Interim Committee on HHS to expand health care representative authority to consent to psychiatric hospitalization and treatment.
The birth of SB 16

- State Senator Monnes Anderson contacted DRO executive Director Bob Joondeph to draft such a statute.

- Mr. Joondeph’s initial draft proposed modifying the statutory form of the advance directive by adding a section to show whether the health care representative had been authorized to consent to short-term hospitalization for treatment of dementia.

- Debate in state legislature ensued…

  New draft of bill- A-Engrossed proposed by state Rep Mitch Greenlick would have allowed a health care representative to consent to psychiatric hospitalization for an unlimited length of time with no review and no opportunity for the principal to object.

  This was opposed by MH advocacy groups and Elder Law section of the Oregon Bar Association among others.
The birth of SB 16

- The bill was redrafted by Bob Joondeph and Tina C. Kitchin, MD, medical director, Seniors and People with Disabilities, Oregon DHS:
  - Redefining dementia as medical/neurological illness
  - Adding a limit to hospitalization duration of 18 days.
  - Providing the principal with the ability to limit or restrict the health care representative’s authority.
What did the final version say?

- Section 1(7) of SB 16 adds a definition for “dementia” to ORS 127.505
  - “Dementia” means a degenerative condition that causes progressive deterioration of intellectual functioning and other cognitive skills, including but not limited to aphasia, apraxia, memory, agnosia and executive functioning, that leads to a significant impairment in social or occupational function and that represents a significant decline from a previous level of functioning. Diagnosis is by history and physical examination.

- Section 2(6) amends ORS 127.535 to provide that hospitalization for up to 18 days for treatment of dementia-related behavior is not prohibited by ORS 127.540 (limitations on authority of health care representative).

- A person can limit health care representative authority by including appropriate language in the “special conditions or instructions” section in Part B of the advance directive form.

- Section 3 of SB 16 also provides a sunset for the bill on January 2, 2012.
What didn’t it say?

- The statute left unspecified whether or not an admission could be consented for in the case of a presumptive diagnosis of dementia.

- It also left unspecified what constituted the forms of mental health treatment which could be authorized by the health care representative.

- It left unaddressed liability concerns in outcomes of treatment where the health care representative’s decisions were overridden or disregarded in emergency situations where life and safety were at stake.

- And, because the bill retroactively granted authority to the health care representative to allow for psychiatric hospitalization designated under all existing ADs, it didn’t address what should happen if the principals never discussed the issue of psychiatric treatment with their health care representative.
And more questions, questions, questions…

- When does the clock start on the 18 days for treatment?
- What happens if additional treatment is required beyond the 18 days?
- Is there a minimum interval of time before the clock can be restarted?
- Who is watching the clock?
- With authorization of the health care representative, are psychotropic medications allowed? Can these medications be administered involuntarily? Can injections be given? Can physical restraint be authorized?
- Who is ensuring protection of civil liberties during this period of involuntary treatment—who is watching us?
Perhaps the most troubling aspects to this legislation are the unanswered questions it leaves with respect to issue of surrogate decision making around psychiatric care for patients with progressive dementias:

- Currently law pertaining to proxy decision making for care decisions in Oregon, and in general, demonstrates a gradual movement towards “advanced planning” with de-emphasis on forms of “substituted judgment” and “best interests” decision making. (Sabatino, 2010; Uniform Health-Care Decisions Act, 1993)

- However, psychiatric treatment rarely enters into these discussions except in those cases where a primary psychiatric disorder has been diagnosed.

- And psychiatric treatment, when provided under current involuntary treatment statutes, has protections for patient autonomy and “rights to refuse treatment” that are not included under the legislative rules of SB16.
The unanswered questions with respect to surrogate decision making under SB16...

- Presumably, the health care representative designated in the AD by the principal, has guidance in the AD regarding what the principal would have wanted in various care circumstances.

- However, the current AD as outlined in Oregon statute does not encourage discussion of theoretic need for psychiatric care or detail aspects of such psychiatric treatment.
The unanswered questions with respect to surrogate decision making under SB16...

- In a review of AD of 126 residents of three Maryland nursing homes with end-stage dementia (Triplett et al, 2008):
  - Completion of ADs positively correlated with Caucasian race, higher education, and access to social supports
  - And ADs were primarily used to restrict, not request forms of care, instructions for treatment were nonspecific with exception of comfort care and pain treatment.

- Studies in fact demonstrate that surrogates correctly predict patient wishes around care not discussed only about two-thirds of the time. (Shalowitz et al, 2006)

- And, in the case of surrogate decision making for those with dementia, due, in part, to the complex impact of dementia on both the physical and cognitive abilities of the principal, there is evidence that there is significant variability among surrogates with regards to understanding/prioritizing goals of treatment, the beliefs and values that underlie these goals and the impact of dementia relevant to personhood that guide treatment decisions. (Kaldjian et al, 2010)
So, what are we left with? Where is the law moving from here?

SB 16 is set to sunset January 2012 in its current form:

- Are there modifications that need to be made?
- Limitations that need to be placed?
- More extensive administrative rule to guide treatment and to delineate when court commitment law should be implemented?
- Should the law be broadened to develop a place for MH advance directives?
Bills that emerged this session:

- Senate Bill 221:
  - This bill would simply make changes enacted by SB 16 permanent, essentially removing the sunset provision.
  - This bill has already passed the Senate and has gone onto the House for approval.

- House Bill 2375:
  - This bill has been abandoned, but would have allowed SB 16’s provisions to sunset as scheduled and then would have removed the prohibition against health care representatives admitting principles for treatment of mental illness as outlined in the AD statutes.
  - This would have opened up the possibility of proxy’s being able to approve involuntary psychiatric hospitalization for treatment of any mental illness for any duration of time, presuming the principal had an AD designating a HCPOA and that the principal were deemed incapacitated.
Discussion/questions…

Special Thanks to:

- Joseph Bloom MD, OHSU
- Bob Joondeph, Executive Director Disability Rights Oregon
- John McCulley, Oregon Psychiatric Association
- Maureen Nash MD, MS Medical Director Tuality Center for Geriatric Psychiatry
- Leigh Schwarz, VA Regional Counsel