

Psychiatrists' Views and Attitudes About Psychiatric Advance Directives

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Psychiatric advance directives (PADs) document a patient's advance instructions (AIs) for treatment and/or designation of a potential proxy decision maker. Approximately 50% of a total of N=167 U.S. psychiatrists who completed a mail survey of their attitudes and views regarding PADs had a favorable opinion of a law authorizing AIs, whereas two-thirds of psychiatrists endorsed proxy decision making legislation. However, 42% perceived important barriers in the service system that would prevent effective implementation of PADs, while 30% considered clinical factors to be important barriers to implementation. Psychiatrists who are correctly apprised of applicable state mental health law are generally more supportive of PADs; they may be more willing to support PADs if they are educated about key aspects of PAD legislation.

Psychiatric advance directives (PADs) allow competent persons, through advance instructions and/or appointment of a surrogate decision maker, to state their preferences for future mental health treatment in the event of an incapacitating psychiatric crisis (Appelbaum, 2004b; Swanson, Tepper, Backlar, Swartz, & Estroff, 2000). PAD statutes are typically designed with two features: 1) advance instructions (AIs), an instructional directive that contains written preferences for mental health care, and 2) health care power of attorney (HCPA), which appoints a proxy decision-maker, both designed to take effect during periods of decisional incapacity associated with relapse of a severe mental illness (SMI). PAD laws were intended to help maintain patients' self-determination during times when they are most vulnerable to loss of autonomy and in need of assistance to make their preferences known and honored (Joshi, 2003; Keefe & Pinals, 2004; Vuckovich, 2003). Advocates for PADs hope that by giving greater voice to patients' treatment preferences, PADs will enhance patients' sense of trust and collaboration with providers, thereby improving the therapeutic alliance and, ultimately, improving treatment adherence and engagement. In addition, PADs may have instrumental clinical value

by imparting relevant treatment history, including information about co-morbid medical disorders, emergency contacts, and side effects associated with specific medications (Srebnik & La Fond, 1999; Swanson et al., 2000).

Although PAD statutes have taken effect in 21 U.S. states—largely within the last decade—little attention has been given to emerging policy questions related to their use. Little is known about how U.S. states can effectively implement PADs, or about their tangible impact on public systems of care. The expected benefits of PADs have yet to materialize, due to systemic barriers preventing their use, lack of resources deployed to assist patients in preparing PADs, and lack of “buy-in” and acceptance of PADs by clinicians (Amering, Stastny, & Hopper, 2005; Backlar, McFarland, Swanson, & Mahler, 2001). Outside the U.S., there is also considerable interest in PADs and other variants of proxy decision making in the United Kingdom, Canada, Austria, Germany, Denmark, the Netherlands, Australia and New Zealand (Amering, Denk, Griengl, Sibitz, & Stasny, 1999; Amering et al., 2005; Atkinson, Garner, & Gilmour, 2004; Cahill, 2004; Danish Council of Ethics, 2002; McKanna, Simpson, & Coverdale, 2000; Papageorgiou, King, Janmohamed, Davidson,

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& Dawson, 2002; Ritchie, Sklar, & Steiner, 1998; Sass, 2003; Srebnik & Brodoff, 2003; Szmukler & Holloway, 2000; Widdershoven & Bernhamans, 2001).

Studies suggest that if given the choice and necessary assistance, the majority of patients with severe mental illness (SMI) would complete an AI and/or HCPA (Backlar et al., 2001; Noble & Douglas, 2004; Srebnik, Russo, Sage, Peto, & Zick, 2003); however, only between 4 and 13 percent of patients with SMI indicate they have executed a PAD (Swanson, Swartz, Ferron, Elbogen, & Van Dorn, in press; Swanson et al., 2003). Most research studies on PADs to date have focused on ethical, legal, and treatment implications of the laws (Joshi, 2003; Srebnik & La Fond, 1999; Swanson et al., 2000; Vuckovich, 2003). However, some recent research is examining outcomes associated with PADs or similar interventions (Henderson et al., 2004; Papageorgiou et al., 2002).

Tempering the enthusiasm of patients and advocates about the potential of PADs are the mixed views of mental health professionals about these legal tools and their legal status (Atkinson et al., 2004; Miller, 1998; Swanson et al., 2003). A recent U.S. Court of Appeals decision in *Hargrave v. Vermont* NO REF?illustrates potential legal conflict over PADs. In this case, a Vermont state law that allowed physicians to override a patient's advance refusal of psychotropic medications was challenged on the grounds that no such override is a feature of general medical advance directives and that such a potential discrimination between psychiatric and medical disorders violates the Americans with Disabilities Act (Allen, 2004; Appelbaum, 2004b; Keefe & Pinals, 2004). Despite this ruling, currently every U.S. jurisdiction with a specific PAD statute permits physicians to "override" medically inappropriate treatment requests in PADs (Appelbaum, 2004a). This legal uncertainty may influence physicians' views of the potential barriers to implementation or effectiveness of PADs

Clinician attitudes and perceived barriers to the implementation of PADs have been examined in several studies in the U.S., the U.K. and elsewhere (Amering et al., 1999; Atkinson et al., 2004; Backlar et al., 2001; Srebnik & Brodoff, 2003; Swanson et al., 2003; Varekamp, 2005). However, questions remain about which barriers are most significant to

key decision-makers in mental health care, especially psychiatrists, and whether these barriers are relevant to both kinds of PAD instruments. Psychiatrists' perspectives on PADs are of particular salience because they often are the first to evaluate patients or make decisions about patients in crisis and often are in a position to "activate" an existing PAD. In addition, they often may counsel or engage patients about the merits or drawbacks to their use. Because North Carolina's PAD statutes separate AIs and HCPA into separate legal mechanisms to be used individually or together, we have the opportunity to explore views and attitudes toward each. In this article, we compare psychiatrists' views of each type legal mechanism and the extent to which similar or distinct attitudes shape support for each. We specifically examine the extent to which North Carolina psychiatrists' views of AIs and HCPA are shaped by their perception of operational barriers in the mental health service system as well clinical barriers related to concerns about patients with severe mental illness preparing PADs. In addition, we investigate whether these perceived barriers are related to certain characteristics of psychiatrists, and the extent to which their understanding of the law is a factor in support for PADs. The purpose of this paper is to address these and other questions regarding psychiatrists' attitudes about PADs.

METHOD

We report results of a survey of 167 psychiatrists practicing in the Southeastern U.S. state of North Carolina. After the Duke University Institutional Review Board approved a survey of mental health professionals, information about psychiatrists was obtained through their professional organization membership roster. Clinicians' names, work addresses, professional setting, age, race, and gender were included in these lists. These lists were then used to draw a random sample of participants. A structured-response questionnaire, the Clinician Attitude Survey, was mailed to 500 randomly selected psychiatrists, yielding a response rate of 32% ($n = 167$). Responders did not differ significantly from nonresponders with respect to age, gender and practice setting. The questionnaire was estimated to take 30-45 minutes to complete. All

participants received a \$50 gift certificate for completing the survey.

Measures

Psychiatrists' Characteristics. We gathered information on the clinician's age, gender, and race. Regarding practice sector, we compared physicians who worked mostly with privately-insured patients vs. those who spent at least 20% of their time in clinical settings serving public-sector patients, (i.e., generally uninsured and publicly insured patients). Physicians were also asked how much time they typically spent with patients (10, 15, 20, 25, 30 or more than 35 minutes), and how often sessions with patients included discussions about the patient's life circumstances beyond their immediate symptomatology (never, sometimes, often, very often, or always). Lastly, physicians were asked about their views of the effectiveness of warnings and reminders to patients about the potential consequences of treatment nonadherence (e.g., having to go to the hospital, or being picked up by the police if they relapsed, etc.). The participants were asked if they felt these warnings and reminders were "effective for improving adherence with treatment" (no, probably not, maybe, probably, or definitely).

Endorsement of Psychiatric Advance Directives Laws. Participants were asked, "Do you approve of North Carolina's law regarding advance instruction for mental health treatment?" and "Do you approve of North's Carolina's law regarding the use of health care power of attorney for decisions about mental health treatment?"

PAD Scenario Decision Making Factors. Participants were asked to respond to a scenario involving a patient's use of a PAD for advance refusal of hospitalization and medication:

Family members of an individual with serious mental illness bring their relative to the emergency department and request that he be admitted to the hospital. The patient has psychotic symptoms and impaired decision-making capacity, but is not dangerous to others or overtly to himself, although he could, by statute, be involuntarily committed for his grossly bizarre behavior. You think he can benefit from hospitalization

and is insured for hospitalization. Previously, while competent, this patient completed an advance directive refusing hospital admissions and treatment with antipsychotic medications. In this situation, would you probably try to follow the advance directive and not hospitalize this patient involuntarily, even if you personally thought inpatient treatment would be in the patient's best interest? (0 = no, 1 = yes).

Participants were then queried about factors influencing their decision-making in this scenario. Factors included: the opinions of colleagues about the treatment decision, opinions of the patient's family, concerns about a potential malpractice suit regarding the decision, the psychiatrists' ethical views of the decision, a belief that involuntary treatment is ineffective and their respect for patient autonomy. All factors were rated on a 5-point Likert scale from 'not important' to 'among the most important.' On the same scale, participants were also asked to rate the importance of the history of suicide attempts in their general decision making processes.

PAD Legal Knowledge. We asked participants to choose the correct multiple choice response to the stem statement: "The North Carolina statute defines 'incapacity' as an individual being currently unable to..." Those who chose the correct response ("Make and communicate treatment decisions") were compared to those who answered incorrectly.

General Legal Barriers. Psychiatrists were asked three questions about their perception of legal barriers to mental health care. The first question addressed physicians' experiences of being legally bound to make decisions which they personally considered to be unethical: "How often do you think that the law requires you to make unethical decisions about patients with serious mental illness?" The second question addresses policies and regulations that were perceived to prevent best clinical practices: "How often do policies and regulations prevent you from making the best clinical decisions for your patients?" Lastly, physicians were asked about their opinions on whether involuntary commitment criteria are too strict: "How often do involuntary commitment criteria prevent you from admitting a patient that you think should be hospitalized?" Responses were rated on a 5-point Likert scale from

'never' to 'always'. The three items were then summed to form a legal barriers scale. The Cronbach's alpha for the scale was ($\alpha = 0.71$), which illustrates good internal reliability of this construct.

Service System and Clinical Implementation Barriers. In order to evaluate barriers in mental health care that might impede the use of PADs, additional queries assessed clinicians' concerns about a range of potential service system operational and clinical barriers to use of PADs. Concerns were rated on a 5-point Likert scale from 'never' to 'very often.' Exploratory factor analysis revealed two underlying PAD barrier constructs: service system operational and clinical barriers. The service system barriers subscale consists of five items: "lack of time to review the document," "lack of communication between staff," "lack of access to the PAD," "lack of staff training or knowledge about what a PAD is, or how it should be handled," and "the extra documentation that may be needed when invoking a PAD." This scale demonstrated good internal reliability ($\alpha = 0.73$) with each item loading on a single factor in a confirmatory factor analysis.

The clinical barriers subscale comprised potential challenges specific to persons with severe and persistent mental illness. This four item subscale includes: lack of "quality information in the PAD," "the patient's potential to change his or her mind about the contents of a PAD during a crisis," "inappropriate treatment requests" within the PAD, and the patients' "risk of violence from treatment refusal in a PAD." This scale also demonstrated good internal consistency ($\alpha = 0.71$) with each item loading on a single factor in a confirmatory factor analysis.

Analysis

Simple descriptive analyses and multivariate logistic regression analyses were used to examine the relative significance of potential factors associated with psychiatrists' support for patient use of advanced instructions (AI) and/or health care power of attorney (HCPA) as well as hypothetical decisions about whether to follow the preferences expressed in the AI in the vignette described above. Independent variables were regressed on whether or not participants agreed to follow preferences expressed in the vignette. Variables were grouped into topical content domains: demographic character-

istics, clinical practice characteristics, PAD decision-making factors, and PAD barriers. Variable reduction was accomplished using stepwise selection with a 0.10 probability inclusion level within each domain. Variables thus selected from the intermediate domain models were then respecified in a final model using the same probability inclusion rule. Odds ratios estimated by this technique estimate the average change in the odds of a predicted outcome (e.g., agreeing to follow the treatment preferences) associated with exposure to independent variables (e.g., respect for patient autonomy). The log likelihood chi-square tests the overall significance of a specified logistic regression model.

Results

Table 1 displays univariate statistics, by domain, for potential predictors of psychiatrists' support for AI and HCPA legislation. For parsimonious representation of the covariates, continuous variables are dichotomized between meaningful categories such as: "important or "very important" versus "only somewhat important or not important".

Sample Characteristics. One hundred and sixty-seven participants responded after random selection from the roster of psychiatrists registered to practice in North Carolina. Of the participants, approximately 76.4% were 45 years of age or older. The mean age of the sample was 52 with a range from 33 to 78. Most of the sample was male (70.7%), and white (87.0%). Almost half of the sample (42.8%) reported working in the public sector practice settings more than 20% of the time. Additionally, about 45.3% reported spending 30 minutes or more per patient appointment. Psychiatrists reported that during their sessions with patients, 66.3% spent time talking with the patients about "patient's family, work, or social life." When asked about their view of the effectiveness of warnings and reminders to patients about the potential consequences of treatment nonadherence (e.g., having to go to the hospital, etc), 67.3% of the participants believed that these reminders and warnings were helpful to increase a mental health consumer's adherence to medication. Finally, 66.7% of psychiatrists were in support of HCPA, whereas somewhat fewer (54.7%) were in favor of AI legislation.

Table 1

Frequency of Dichotomized Covariates (N =167)	n	%
Demographics		
Age		
45 and older	126	76.36
Gender		
Male	118	70.66
Race		
Non-white	21	13.04
MD practice characteristics		
Works in the public sector (more than 20% of the time)	71	42.77
Spends 30 or more minutes each session for patient care	73	45.34
Talks with patient about life (very often-always)	108	66.26
Believes use of adherence warnings and reminders is not important	55	33.74
In favor of health care power of attorney (HCPA) legislation	110	66.67
In favor of advance instruction (AI) legislation	89	54.27
PAD decision making factors		
Decision to not hospitalize a patient due to PAD request		
Colleagues opinions	124	75.15
Patient's family's opinion	142	86.06
Malpractice suit potential	82	49.7
Clinician's ethics	148	89.7
Believes involuntary commitment ineffective	145	10.5
Respect for patient autonomy	133	81.1
History of suicide attempts as decision factor (important-amongst the most important)	150	91.46
Barriers to PADs		
Experience legal barriers to mental health care (often-always)	12	7.19
Knowledge of PAD law	63	37.72
Service system barriers to PADs (often-very often)	70	41.92
Clinical barriers to PADs (often-very often)	51	30.54

PAD scenario decision making factors. The psychiatrists endorsed the following as the most important factors in decision making about honoring or overriding the prior written treatment preferences of a patient refusing treatment in a psychotic state: their own personal ethics (89.7%), opinions of the patient's family (86.1%), respect for patient autonomy (81.1%) opinions of colleagues (75.1%), malpractice suit potential (50.0%), and belief that involuntary treatment is ineffective (10.5%). Additionally, 91.5% of psychiatrists reported that a

history of suicide attempts was an important factor in the decision whether or not to follow a patient's previously-expressed treatment preferences.

Barriers to PADs. The psychiatrists endorsed the following as the most important barriers to implementation of PADs: service system operational barriers (41.9%), clinical barriers (30.5%) and related legal barriers to mental health practice (7.2%). In addition, only a minority (37.7%) correctly understood a key element of the PAD statute relating to the threshold determination of incapacity.

In order to distinguish attitudes related to support of AI versus HCPA legislation we examined predictors of support for each form of these legal instruments. The first column in Table 2 displays the association of support for AI legislation with individual items in each of the four content domains: demographics, practice characteristics, PAD scenario decision making factors and barriers to PADs. Bivariate relationships between individual predictors and support for AIs are presented in the common odds ratios shown in the first column. In the demographic domain, increasing age was associated with being more supportive of AI legislation (OR 1.03, CI 1.00, 1.06, $p < 0.05$). In the practice characteristic domain, psychiatrists who reported more time for patient visits and used the visit to inquire broadly about the patient's life were more supportive of AIs compared to their counterparts with less time and more symptom-focused visits (OR 1.33, CI 1.04, 1.71, $p < 0.05$ and OR 1.39, CI 1.00, 1.91, $p < 0.05$, respectively). In the PAD scenario decision-making factor domain, psychiatrists who were more concerned with malpractice suit potential were significantly less supportive of AIs (OR 0.49, CI 0.31, 0.78, $p < 0.01$), while those strongly endorsing the importance of their professional ethics in decision-making were more supportive of AIs (OR 1.64, CI 1.03, 2.61, $p < 0.05$). Finally, in the PAD barriers domain, psychiatrists who had a better understanding of relevant law were more supportive of AIs (OR 1.97, CI 1.03, 3.76, $p < 0.05$) and those who identified more service system and clinical barriers to PADs were less supportive of AIs, compared to those less concerned about these barriers (OR 0.87, CI 0.78, 0.98, $p < 0.05$ and OR 0.86, CI 0.75, 0.99 $p < 0.05$, respectively).

The second column in Table 2 displays adjusted odds ratios for the variables within each domain, resulting from multivariable logistic regression analyses. Each domain model was initially tested independently, then predictors selected at $p < 0.10$ from each domain were entered into a final model in the final column. Three predictors that were significant in bivariate analysis were rendered nonsignificant in the domain models: age, use of the visit to inquire more broadly about the patient's life, and clinical barriers to PADs.

The final multivariate model displayed in Table 2, column 3, demonstrates that psychiatrists most

concerned with malpractice suit potential were less supportive (OR 0.55, CI 0.33, 0.92, $p < 0.05$), those endorsing the importance of professional ethics in decision making more supportive (OR 1.85, CI 1.10, 3.08, $p < 0.05$) and those identifying more service system barriers to PADs were less supportive of AIs (OR 0.85, CI 0.75, 0.98, $p < 0.05$).

In Table 3, the first column displays the association of support of HCPA legislation with individual items in each content domains. In the demographic domain, no variables were significantly associated with HCPA support. In the practice characteristic domain, psychiatrists reporting more time for patient visits were more supportive of HCPA legislation (OR 1.49, CI 1.14, 1.94, $p < 0.01$). In the PAD scenario decision-making factor domain, psychiatrists expressing most concern for the patient's family's opinion about treatment decisions were more supportive of HCPA (OR 2.06, CI 1.12, 3.79, $p < 0.05$) and those most concerned about malpractice suit potential were less supportive of HCPA legislation compared to their counterparts with the differing views (OR 0.59, CI 0.37, 0.94, $p < 0.05$). Finally, in the PAD barriers domain, psychiatrists who identified more service-system and clinical barriers to PADs were less supportive of HCPA legislation than their counterparts with differing views (OR 0.86, CI 0.76, 0.97, $p < 0.05$ and OR 0.86, CI 0.75, 0.99 $p < 0.05$, respectively).

The second column in Table 3 displays adjusted odds ratios for the variables within each domain, resulting from multivariable logistic regression analyses. While a significant bivariate association was found between clinical barriers to PADs and support for HCPA, this variable was rendered nonsignificant in the multivariate domain model of barriers to PADs. In addition, within the PAD scenario decision-making factor domain, psychiatrists who endorsed a history of suicide attempts as an important factor in honoring or overriding treatment refusal in a psychotic patient were more supportive of HCPA legislation—a relationship strengthened to the level of significance in this model (OR 1.90, CI 1.13, 3.17, $p < 0.05$).

The final multivariate model displayed in Table 3, column 3, is essentially unchanged from the previous domain models, with the exception that the previous association with malpractice suit concern is rendered nonsignificant and psychiatrists who had

Table 2

Model for Pro-Advanced Instruction	Bivariates Pro-AI		Domain Model Pro-AI		Multivariate Model Pro-AI	
	OR	95% C. I.	OR	95% C. I.	OR	95% C. I.
Demographics						
Age	1.03	1.00-1.06*	1.03	1.00-1.06~		
Male	1.28	0.65-2.54				
White	2.14	0.91-5.06				
			2 log likelihood = 219.70 Somers's D = 0.185			
MD practice characteristics						
Public sector practice	0.53	0.28-1.00~				
Time for patient care	1.33	1.04-1.71*	1.33	1.04-1.71*	1.27	0.97-1.67~
Talk with consumer about life	1.39	1.00-1.91*				
Effectiveness of adherence warnings and reminders	0.63	0.32-1.22				
			2 log likelihood = 211.99 Somers's D = 0.21			
PAD scenario decision making factors						
Decision to not hospitalize a patient due to PAD request						
Colleagues opinions	1.18	0.75-1.86				
Patient's family's opinion	1.65	0.94-2.92~	1.67	0.90-3.11		
Malpractice suit potential	0.49	0.31-0.78**	0.44	0.27-0.72**	0.55	0.33-0.92*
Clinician's ethics	1.64	1.03-2.61*	1.68	1.03-2.74*	1.85	1.10-3.08*
Believes involuntary commitment ineffective	1.13	0.72-1.78				
Respect for patient autonomy	1.43	0.90-2.27				
History of suicide attempts as decision factor	1.31	0.82-2.08				
			2 log likelihood = 201.19 Somers's D = 0.225			
Barriers to PADs						
Legal barriers to mental health care	0.98	0.84-1.14				
Knowledge PAD law	1.97	1.03-3.76*	2.13	1.09-4.15*	2.01	0.96-4.19~
Service system barriers to PADs	0.87	0.78-0.98*	0.86	0.76-0.97*	0.85	0.75-0.98*
Clinical barriers to PADs	0.86	0.75-0.99*				
			2 log likelihood = 215.37 Somers's D = 0.287		2 log likelihood = 185.07 Somers's D = 0.431	

~ trend (.05-1.0)

* $p < .05$ ** $p < .01$ *** $p < .001$

Table 3

<i>Model for Pro-Health Care Power of Attorney</i>	Bivariate Model Pro-HCPA		Domain Models Pro-HCPA		Multivariate Model Pro-HCPA	
	OR	95% C. I.	OR	95% C. I.	OR	95% C. I.
Demographics						
Age	1.02	0.98-1.05				
Male	1.62	0.76-3.46				
White	1.77	0.76-4.10				
MD practice characteristics						
Public sector practice	0.62	0.32-1.19				
Time for patient care	1.49	1.14-1.94**	1.49	1.14-1.94**	1.45	1.09-1.93*
Talk with consumer about life	1.29	0.95-1.77				
Effectiveness of adherence warnings and reminders	0.75	0.37-1.51				
2 log likelihood = 190.36 Somers's D = 0.287						
PAD scenario decision making factors						
Decision to not hospitalize patient due to PAD request						
Colleagues opinions	1.34	0.83-2.16				
Patient's family's opinion	2.06	1.12-3.79*	2.22	1.16-4.25*	2.29	1.13-4.65*
Malpractice suit potential	0.59	0.37-0.94*	0.50	0.31-0.83**		
Clinician's ethics	1.49	0.94-2.36~				
Believes involuntary commitment ineffective	0.86	0.54-1.36				
Respect for patient autonomy	1.17	0.73-1.89				
History of suicide attempts as decision factor	1.80	1.10-2.95	1.90	1.13-3.17*	1.88	1.08-3.24*
2 log likelihood = 189.3 Somers's D = 0.381						
Barriers to PADs						
Legal barriers to mental health care	0.84	0.72-1.00~				
Knowledge of PAD law	1.82	0.91-3.64~	2.03	0.99-4.16~	2.26	1.01-5.07*
Service system barriers to PADs	0.86	0.76-0.97*	0.84	0.74-0.96**	0.82	0.71-0.95**
Clinical barriers to PADs	0.86	0.75-0.99*				
2 log likelihood = 198.42 2 log likelihood = 167.19 Somers's D = 0.338 Somers's D = 0.496						

~ trend (.05-1.0)

* $p < .05$ ** $p < .01$ *** $p < .001$

a better understanding of the relevant law were shown to be significantly more supportive of HCPA legislation than their counterparts who were less cognizant—a relationship strengthened to the level of significance when controlling for the other factors in this final model (OR 2.26, CI 1.01, 5.07, $p < 0.05$).

DISCUSSION

This study examined the attitudes of psychiatrists in North Carolina about relatively new legislation authorizing psychiatric patients to create PADs through two related statutory mechanisms—advance instructions and appointment of a proxy decision maker—both intended for use during periods of incapacitation. Two thirds of psychiatrists were in support of HCPA legislation, whereas somewhat fewer (55%), were in support of AI legislation. Psychiatrists who identified more services system barriers to PAD implementation were less supportive of both AI and HCPA legislation. Understanding of the relevant law was also common to support of AI and HCPA legislation. On the other hand, there were some differences that emerged. Psychiatrists with less concern about malpractice liability and greater endorsement of the importance of personal ethical practice were more supportive of AIs. Psychiatrists with more time for patient visits, who gave greater weight to family's opinions about treatment decisions, and gave greater weight to suicide history in decisions about honoring patients' treatment preferences were more supportive of HCPA legislation.

One of the most salient findings involves physicians' attitudes about PADs in relation to perceived barriers to PADs. Support for both statutory provisions was associated with fewer perceived service system operational barriers to implementation. Psychiatrists with less concern about service system barriers to PAD implementation—barriers such as lack of access to the documents and lack of staff knowledge about them—were most supportive of both AI and HCPA legislation. This suggests that physicians' views of PADs are influenced to some extent by an appraisal of a mental health care system's capability to effectively implement these new legal provisions. Psychiatrists with a dim view of these capabilities

understandably had diminished enthusiasm for both statutory mechanisms. The data therefore suggests that, in order to bolster acceptance of PADs among psychiatrists, efforts to improve access to PADs and to increase clinician knowledge will be critical.

Another important finding was that higher support for AIs was related to fewer malpractice concerns and high endorsement of the importance of personal ethical practice among psychiatrists. However, fewer malpractice concerns predicted support for HCPA legislation in all but the final multivariate analyses. This suggests that AIs may be somewhat more a focus of malpractice concern than HCPAs. In part, this may reflect a concern that advance instructions as stand-alone treatment authorizations have greater potential for conflict with accepted practice standards – thus exposing the psychiatrist to heightened legal liability. On the one hand, the psychiatrist could be sued for malpractice if there is an adverse outcome resulting from following a patient's stand-alone advance request to forego treatment or to receive non-standard treatment; on the other hand, if the psychiatrist denies the advance request and provides treatment contrary to the patient's wishes, the patient could bring a legal action for being treated without consent.

In contrast, the HCPA mechanism may seem to involve less potential for conflict in treatment decisions, and thus may stimulate fewer malpractice concerns. A proxy decision-maker—typically a family member—may be seen as more “reasonable” arbiter of treatment decisions or someone easier to engage in dialogue about treatment options. In turn, a collaborative dialogue with a proxy decision-maker may seem to reduce malpractice suit potential. The positive relationship between importance of personal ethical practice and support of AIs may reflect the psychiatrist's ethics-based support for greater patient autonomy.

Why was support for HCPA legislation stronger among psychiatrists with more time for patient visits, who gave greater weight to families' opinions about treatment decisions, and who had a better understanding of the relevant law? Psychiatrists with more time for patient visits may have viewed themselves as having more flexibility to encourage collaboration with significant others—such as potential proxy decision makers—in the treatment process. Alternatively, these may have been psychiatrists who made

more time for such collaboration. Similarly, these clinicians may have given additional weight to family concerns about treatment decisions, because they viewed family members as important partners in the treatment process. Psychiatrists with better knowledge of the relevant law may have been more aware that the law attempted to ameliorate their legal risk concerns or minimally impinged upon their medical discretion.

Many psychiatrists acknowledged little direct clinical experience working with patients who had executed PADs. As a result, the attitudes expressed in this survey may reflect inchoate opinions about imagined, rather than real, situations; these attitudes will likely continue to evolve and perhaps crystallize in response to actual patient encounters over time. This may be why perceived barriers to PADs implementation were most readily endorsed; in the absence of experience, potential logistical problems, difficulties, and concerns about unknown situations readily come to mind. In addition, the survey was conducted during a period of rapid change in the NC public mental health system and many participants may have also been expressing latent skepticism about the evolving capability of the public mental health system.

This study has several limitations. First, these cross-sectional data cannot demonstrate causal connections between variables; rather, they show statistical associations, which may be consistent with a several causal formulations. Next, the psychiatrist sample involved some self selection, favoring those who responded to a mail invitation to complete the survey. However, data on nonresponders give no reason to suspect that this procedure produced a biased sample with respect to PAD attitudes. Further, our multivariate analyses controlled for a number of clinician characteristics, including age, experience with severely ill patients, work setting, race, and gender.

In sum, psychiatrists appear to have somewhat more enthusiasm for use of proxy decision-makers rather than written advance instructions to represent the treatment preferences of their patients during periods of psychiatric incapacity. However, a majority of psychiatrists still endorsed use of written instructions. While these views and attitudes are likely still formative, their attitudes towards PADs should be understood in the context of a number of

countervailing pressures and concerns that affect their practices, such as concern about the mental health service system's ability to effectively implement PADs, concerns about adhering to professional ethics, concerns about standards of care, and the potential legal liability attendant to honoring the previously expressed preferences of an incapacitated patient. Psychiatrists who are correctly apprised of applicable state mental health law are generally more favorable about these legal instruments, which suggests that clinicians will likely be more willing to support PADs if they are educated about key aspects of PAD legislation.

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