ORIGINAL ARTICLE

Is the anticipated consent to treatment in advance directives a solution to compulsory treatment in forensic psychiatry?

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As a result of a German Federal Constitutional Court decision on compulsory treatment, in its state Law the federal state of Hesse has newly regulated the possibility of compulsory treatment (Section 7 Paragraph 2 of the Hesse Law on the Enforcement of Court-ordered Hospital Treatment) and expressly incorporated the observance of a patient's advance directive as defined by Sections 1901a and 1901b of the German Civil Code (Bürgerliches Gesetzbuch [BGB]). Having been sentenced to a hospital treatment order under section 63 of the German Criminal Code (Strafgesetzbuch [StGB]) in the Vitos Haina Forensic Psychiatric Hospital, thirteen patients with schizophrenia stated in a patient's advance directive that they wished to be treated with certain antipsychotic medication in case of a recurring psychotic episode. In particular, the patient's advance directive stated that this treatment should be compulsory if necessary. Based on a case vignette this article delineates both the motivation of the patients for such a patient's advance directive, as well as the legal limitations and the enforceability of such a patient's advance directive. There is no prevailing view in the jurisdiction or literature on the utilization of a patient's advance directive to guarantee an explicitly desired treatment in case of incapacity for consent. This article wishes to highlight the perspectives of those directly affected and to encourage discussion. While of special interest for forensic psychiatry, these considerations may also be of importance for treatment considerations in general psychiatry.

Key words

Patient's advance directive, Anti-psychotic medication, Coercive treatment, Forensic psychiatry, General psychiatry

Introduction

In Germany, the discussion about the use of compulsory treatment has been rekindled by changes in the legal system.

Questioning, debating, and defining the legal possibility of compulsory treatment is essential in contemporary psychiatry since compulsory treatment is a significant burden on patient autonomy.

Yet, the patient, who is assigned against their will and for reasons of protection (general psychiatry), or was declared not to be criminally responsible for the crime committed (forensic psychiatry), is often not motivated for treatment but poses a risk for fellow patients or fellow inmates, staff and him/herself.

The following article introduces the possibility of an anticipated consent to treatment in advance directives (Ulysses clause) as one means to solve this problem.

Legal aspects of compulsory treatment in the forensic context

The German Criminal Code (Strafgesetzbuch [StGB]) Section 63 sets out the legal grounds for involuntary placement in a forensic psychiatric hospital for persons who are declared not criminally responsible or who have diminished responsibility for a criminal offense. Placements under Section 63 may be indefinite.

Whether the compulsory treatment of a person detained under section 63 of the German Criminal Code (Strafgesetzbuch [StGB]) is permissible depends on the regulations governing such detention in the respective state of Germany. In the state of Hesse this matter is governed by

section 7a of the Law on the Enforcement of Court-ordered Hospital Treatment in a Psychiatric Hospital, and in a Drug Rehabilitation Facility of the State of Hesse (Hessisches Maßregelvollzugsgesetz [hereinafter HMRVG]). It is specified that:

(1) Medical examinations and treatments, as well as nutrition, are permissible against the natural will of a detained person who is incapable of giving consent if:

1. *significant danger for the life of the detainee or a serious impairment to their health exists,*
2. *this is necessary to restore the detainee's ability to take decisions and action, and if there are grounds to assume that without the implementation of the measure in question, the detainee's discharge will not be possible.*

(2) Medical examinations and treatments, as well as nutrition, are permissible against the natural will of a detained person if significant danger to the life, or a serious impairment of the health, of the persons exists.

(3) Compulsory measures as defined in subsections 1 and 2 may be ordered only if:

1. *attempts to produce the consent of the detainee to the examination, treatment, or nutrition that is based on trust, have not been successful,*
2. *the detainee has been informed of the order, and a physician has explained the nature, scope, and duration of the therapeutic measure,*
3. *the measure required to avert danger to life, limb, or health, or to restore freedom, does not entail unreasonable stress or consequences for the detainee and more gentle measures do not promise any success, and*
4. *the anticipated benefit of the measure clearly outweighs any possible harm from the failure to provide treatment.*

In the event of imminent danger, the requirements defined in numbers 1 and 2 can be disregarded.

(4) Compulsory measures pursuant to subsections 1 and 2 shall be initiated and monitored by a physician in accordance with section 2, sentence 6. The reasons for a hospital treatment order as defined in subsections 1 and 2, the conditions defined in subsection 3, and the measures taken (e.g. their compulsory character, the manner of implementation , the monitoring of effects, and the sequence of examinations and course of treatment) are to be documented.

(5) Treatment based on an order as defined in subsection 3 shall be subject to the prior approval of the supervisory authority. Such approval shall not be required if danger is imminent and the approval is procured immediately after initiating the measure. Application for a decision of the court against the order may be filed in accordance with section 109 of the German Prison Act (Strafvollzugsgesetz [StVollzF]).

(6) To ensure the protection of health and hygiene of the detained person, compulsory physical examination is permitted if it is not combined with an invasive physical intervention.

The question of compulsory treatment arises only when a patient refuses to consent to drug therapy despite the therapy regime having been explained on several occasions, and attempts having been made to reach agreement with the patient. The German Federal Constitutional Court (Bundesverfassungsgericht [BVerfG]) once again clarified, in its decisions from the years 2011 and 2013, that compulsory treatment is fundamentally possible [1]), although it imposed far-reaching specifications for an adequate legal framework [1-3].

According to these specifications, compulsory medical treatment represents a serious intervention in the basic rights of a patient, as derived from article 2, subsection 2, sentence 1 of the Basic Law for the Federal Republic of Germany (Grundgesetz [GG]). In individual cases, such intervention can be justified to achieve the goals of the forensic commitment. Yet, there are strict requirements for the permissibility of such intervention in terms of proportionality [1]. These apply to both the material requirements for such an intervention and to the securing thereof by precautionary steps under procedural law.

The requirements to be satisfied for such an intervention must be legally regulated with sufficient clarity and specificity.

In the state of Hesse, section 7a, paragraph 1 of the HMRVG stipulates that:

Treatment regimens…are permissible…against the natural will of a detained person who is incapable of giving his consent if … significant danger for the life of the detainee or a serious impairment to his health exists" or if *"this is necessary to restore the detainee's ability to take decisions and action, as otherwise his discharge will not be possible*.

The law postulates that every human being has free will. Crucial for the existence of free will is cognitive capacity and the ability to act accordingly. When one of these elements is missing, there is no free will but natural will. Every human being, even mentally ill patients, are able to have a natural will. This is irrespective of whether this will is reasonable from the point of view of a third party. The natural will is a legal concept, which encompasses the actual intentions, desires, valuations, and intentions of a person, even if the latter is in a state of mental disturbance. Clarifying this with an obvious example: Ulysses wanted to hear the Sirens' song although he knew that doing so would render him incapable of rational thought. When Ulysses put wax in his men's ears so that they could not hear, had them tie him to the mast so that he could not jump into the sea, ordered them not to change course under any circumstances, and to keep their swords upon him and to attack him if he should break free of his bonds, he expressed his free will. When he upon hearing the Sirens' song, driven temporarily insane and struggling with all of his might to break free so that he might join the Sirens, which would have meant his death, he expressed his natural will.

In addition, compulsory treatment as defined in section 7a, subsection 2 of the HMRVG can be possible in the presence of significant danger to the life or serious impairment to the health of third parties.

When considering options for compulsory treatment, an advance directive must be taken into consideration (HMRVG section 7, subsection 2). The legislature is thereby extending the scope of an advance directive drawn up by the patient, even when the patient is in forensic psychiatric care. Other federal states have also explicitly included this in the texts of their laws [4,5].

The regulations governing the requirements for advance directives drawn up by patients as defined in section 1901a of the German Civil Code (Bürgerliches Gesetzbuch [BGB]) came into effect in 2009 [6]. With this amending law, Germany has formalized the use of advanced directives in legislation. The law is therefore colloquially referred to as the law on advanced directives ("Ulysses clause" in other countries).

In the advance directive, the patient may refuse future courses of treatment, limit them, or consent to them in advance [7]. The specifications must be in accord with the current life and treatment situation [6]. In the event of an acute psychotic episode, for example, the use of a certain antipsychotic drug may be ruled out or specified, or the use of all medication may be banned. Thus, the individual concerned is able to rule out compulsory treatment by means of their advance directive [8]. On the other hand, thanks to the statutory ruling in section 1901a of the German Civil Code (BGB), the individual concerned can actually express their wish for a certain course of treatment in certain circumstances.

Whether or not this goes as far as to request a course of treatment against one's own will in the context of the advanced directive is to be discussed in the following section, with reference to the practical experience of a forensic unit as well.

Practical aspects of advance directives: a case illustration

Up until now there have been two patients at the Vitos Hospital for Forensic Psychiatry in Haina who drew up advance directives prior to their admission to hospital in which they refused a pharmacological course of treatment (in one case the patient refused psychiatric examination and

the formulation of a psychiatric diagnosis as well). In such cases, it is necessary to determine as accurately as possible whether the patient actually considered placement in forensic detention when the advanced directive was drawn up ("in accord with the current life … situation"). This particular situation will have been anticipated in only the rarest of cases [9].

In terms of detention in a forensic unit, it must be noted that treatment may be carried out, if there is a danger to third parties (endangerment of third parties) [9-11], even when the patient's advance directive states that treatment is to be refused, and that state law provides the option of compulsory treatment [4,12].

By contrast, there are now 13 patients at the Vitos Hospital for Forensic Psychiatry in Haina who - in the course of their treatment there - have specified in their advance directives that in the event of an acute psychotic episode they wish to be treated with certain neuroleptic medications *even in the form of compulsory treatment*. The patients were well into or fully in remission, they had full insight into their illnesses and treatments after education on psychological and psychiatric illnesses and treatments, and they felt that their quality of life had clearly improved in remission. They realized and/or considered it possible that they would refuse, again, to be treated appropriately when in an acute psychotic state, and subsequently drafted advance directives to prevent this: they specified that if they should experience an acute psychotic state in the future, they should be treated even against their will (i.e. coerced into treatment). The patients viewed this as the best chance of going into swift remission again, and hence, minimizing the danger of lasting impairment (e.g. residual symptoms). When drafting their advance directives, upon request, the patients were given detailed legal advice and support by the hospital's in-house attorney, or they consulted with an external attorney, or their court-appointed authorized carer, for advice.. Prior to this, their ability to give informed consent was checked and attested to by a psychiatric specialist.

The following case history illustrates a prototypical situation:

Case illustration

Mr. T. was born in 1981. His parents separated when he was three years old; otherwise his childhood was unremarkable. Over the course of his youth and adolescence, he experienced problems with concentration. Moreover, Mr. T. was expelled from school in the 8th grade; his subsequent attendance at a vocational high school also ended with expulsion. All social relationships suddenly came to an abrupt end. In retrospect, it appears that Mr. T. was already in the prodromal phase of his illness at that time.

In 2004, the existence of a psychosis was suspected during an assessment. In 2005, the patient underwent compulsory treatment as an inpatient in a psychiatric ward for the first time after posing a danger to himself and damaging property. At that time Mr. T. was suffering from acoustic hallucinations and distressing delusions. However, no consistent further treatment with medication was provided. Further civil commitments to psychiatric units followed, during which the diagnosis of Schizophrenia was repeatedly confirmed. Mr. T. first came to the attention of the criminal justice system in 2007 when he committed theft and drove a vehicle without authorization. There followed a number of convictions for unlawful entry, damage to property, and threatening behavior/intimidation.

Finally, during an acute psychotic episode in 2010, Mr. T. committed the offenses of assault with actual bodily harm, as well as resistance to and insulting law enforcement officers, for which he was committed by court order to forensic psychiatric care under Section 126a of the German Code of Criminal Procedure (Strafprozessordnung [StPO]). According to Section 126a of the German Code of Criminal Procedure (Strafprozessordnung [StPO])), persons who are suspected of having committed a criminal offense may be admitted to a psychiatric hospital if there are urgent reasons to assume they were not criminally responsible or have acted in a state of diminished responsibil-

ity. A psychiatric assessment was carried out.

During his admission to hospital, he displayed dysphoric agitation, formal thought disorder and mildly delusional ideas with regard to the "military" and the "German armed forces". Due to his consistently negative and hostile attitude, proper structured conversations with him were hardly possible; he absolutely refused all treatment with medication and other forms of therapy.

Mr. T. appealed against the sentence of March 2011 for the placement in a forensic psychiatric hospital in accordance with section 63 of the German Criminal Code (Strafgesetzbuch [StGB]). The version of the Forensic Commitment Act of the State of Hesse in force at that time did not allow compulsory treatment.

The frequency and intensity of his impulsive outbreaks of aggression increased in mid-2011. After Mr. T. was informed that the German Federal Court of Justice [Bundesgerichtshof] had thrown out his appeal, he barricaded himself in his room. Due to this escalation, an intervention with medication was carried out as part of an emergency treatment (Section 34 of the German Criminal Code [StGB]), after which Mr. T. said he would be prepared to take medication on a voluntary basis.

The consistent intake of an antipsychotic drug resulted in a rapid regression of the acute symptoms, and his delusional thought disorders, impulsive behavior and mood swings attenuated significantly. In the further course of treatment, it increasingly became possible to discuss the offenses for which he had been placed in a forensic psychiatric unit and factors relevant to these offenses. Finally, in February 2012 it was possible to move the patient from the secure unit to a therapy ward so that he could be treated appropriately with regard to his criminal behavior and his medication optimized.

After a few weeks, it was possible to grant him extensive privileges. Under the increasing demands of the everyday routine, Mr. T. soon proved to be more thin-skinned and fatigued, so that his medication was switched from olanzapine to aripiprazole. After this, he was clearly more agile and more relaxed in his contact with others.

Mr. T. then joined a psychoeducation group, via which he acquired an understanding of his disorder and was able to relate the acquired knowledge to his own case history, so that he developed differentiated insight into his illness and treatment. He himself stated that he wanted to learn to handle the constraints resulting from his illness in the best possible way. He said that the treatment had rendered him more flexible in thinking, that he felt more relaxed, that he was not so distrustful, and that he found life worth living again. In February 2013, Mr. T. was transferred to an open rehabilitative ward and mastered this transition without any difficulty at all.

In May 2013, the patient stated that he wished to draft an advance directive. The focus of the directive was to be on pharmacological treatment, even against his possibly expressed natural will, if, owing to acute psychotic decompensation, he failed to see the necessity for treatment, so that he would be subjected to compulsory treatment. The patient explained that his involvement with the psychoeducation group for schizophrenic patients in conjunction with the switching of his medication from olanzapine to aripiprazole contributed to the development of this desire. He was able to recognize that he had schizophrenia and that after his medication had been changed, he felt very much mentally intact again and free from any side effects. He added that the combination of psychoeducation and successful treatment had nurtured the desire in him not only to be fully healthy, but also to remain that way.

Beginning in summer 2013, Mr. T. completed an internship as a municipal green area maintenance worker and street cleaner and was later hired on a permanent basis. In April 2015, Mr. T. was released on probation.

Looking back, Mr. T. said he found the detention and compulsory treatment extremely unpleasant and that he considered

it wrong at the time. He stated that today, however, he saw the compulsory treatment as a “crass method” that in his case had actually worked, so that he wanted to specify compulsory treatment in an advance directive as the method of choice for himself in the event that he experienced recurring episodes of illness.

Conclusion

In light of the fact that in the scenarios being discussed, these are patients who are aware that they are committed to court-ordered treatment in a forensic facility, and who are familiar with the phasic course of their disorder. With respect to the advance directive, the following factors should be considered:

1. In a phase when the patient is capable of expressing informed consent, the affected patient wishes to deliberately specify arrangements for treatment for the phases in which the patient is not capable of giving informed consent.
2. In the event of such a situation, the patient may be able to contribute actively towards shortening the acute treatment (possibly by several months), as drug treatment can be initiated immediately (subject to compulsion if necessary). In the German federal state of Hesse, treatment given against the will of the patient during court-ordered treatment in a forensic facility can be carried out without a corresponding advance directive only after a time-consuming application procedure (section 7a HMRVG).

It remains necessary to examine the legal question of whether a patient is able to stipulate in advance that if they are to become incapable of giving consent as a result of their disorder, compulsory measures can nevertheless be carried out contrary to expressed natural will. These questions are discussed in the literature from a variety of standpoints, yet there is still no conclusive solution that serves the interests of the persons concerned.

In conjunction with this, the following legal issues arise: can the patient consent in advance to a compulsory measure via a directive drawn up in anticipation thereof? Must the patient’s natural will, subsequently declared and in conflict with the advance directive (no treatment now!), be deemed a revocation of the previously drafted directive? This is tied to the question of whether the patient must be capable of giving his consent in order to declare his revocation.

None of these issues have been consistently decided in the legal literature or jurisprudence, nor have they been rigorously pursued to achieve solutions.

In particular, the aspect of the *ability to give consent in declaring a revocation of the patient’s directive* has been the focus of controversy [7,13]. Yet, the opinion [14] that would accept a revocation as valid merely by virtue of the articulation of a natural will is unconvincing. This only debases the function of such a patient directive [11]. In particular, in the cases discussed here, in which the patient is familiar with the progression of their disorder and seeks to regulate precisely this situation, to interpret another natural will expressed in a condition of incapability (of giving consent) would not be appropriate [as with 7,15,16]. This is particularly true if, when in a state of capability to give consent, the patient explicitly stipulates the wish to be treated, even if they subsequently declare or wish something else. In this respect, it is recommended that the patient additionally specify in their advance directive that declarations are to be deemed valid even when contradicted by their natural will [17]. For this reason, the natural will declared later on, when the patient is incapable of giving consent, *cannot be deemed* to be a revocation of the patient’s existing advance directive. This is the only way that adequate consideration of and compliance with the will expressed in the patient’s advance directive will be ensured.

This inevitably leads to the question as to whether consent can be given lawfully and in anticipation to *compulsory treatment*, for this is a course of treatment against the expressed and contradictory natural will of the patient. Here as well, there is no clear answer in the literature. Three legal positions are to be distinguished. The question

is answered in the affirmative by Götz [15] and Hoffmann [16], as well as Bohnert [18] although Götz and Hoffmann both express doubts as to whether this would be in keeping with the current life and treatment situation. Götz [15], however, sees a possible solution in which the author of the advance directive, in describing the situation of therapeutic application, makes it clear that they are aware of the outcome of their declaration and that their stipulations in the advance directive apply even if at a subsequent time their natural will conflicts with them. A compromise is suggested in the literature that although it is possible to consent to compulsory treatment in advance, it should not be possible to waive procedural safeguards [11,13].

For the cases discussed here in which the patient, in the awareness of their condition and with the understanding of the commitment to and placement in a forensic unit and in the knowledge of the completely individual course of their own illness, drafts an advance directive specifying that they should receive treatment even if their declared other will is against this, the only logical conclusion is that this valid directive cancels other prerequisites and procedural requirements for compulsory treatment in a forensic unit (in the state of Hesse: approval of the supervisory authority as specified in section 7a of the HMRVG) and in the legislation governing official court-appointed carers (subject to the decision of a judge). This all the more so since consent to compulsory treatment is not unethical per se [18,19]. Thus, the patient's right to exercise self-determination with foresight and planning could be preserved by means of a binding directive that will be invoked only in the future. This option should at least be recognized in the cases described here. It remains to be seen whether the wishes for treatment specified in a patient's advance directive will hold up under judicial review.

Conflict of Interest: none

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