By **Moira S. Laidlaw**

Mental Health Directives in Estate-Planning Engagements

Ask clients about underlying psychiatric conditions

As estate-planning professionals, we help clients plan in the event of incapacity, not just death. While clients may come into our offices worried about death and taxes, we educate them that equally worrisome, and sometimes far more legally complicated, is incapacity. We proceed to help them guard against it by using our mainstay advance directives: health care proxies, livings wills and powers of attorney. But are we using all of the advance directives available to us? One often unknown and underutilized directive is the psychiatric advance directive (PAD).

Why Needed?

PADs are critical because during an acute psychiatric episode, patients lack capacity to give informed consent for treatment. Involuntary treatment laws are designed to safeguard an individual's right to refuse treatment, requiring an individual to fully decompensate and become a danger to self or others before treatment may be delivered without consent.[1] This kind of crisis intervention model leads to short-term stabilization of seriously mentally ill patients rather than promoting earlier intervention.

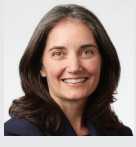
Psychiatric issues don't relate to a small part of the population. Mental illness is universal and pervasive, with one in five individuals in the United States suffering from any mental illness and one in 20 individuals suffering from serious mental illness.[2] While prevalence for mental illness is high, the statistics on treatment are shockingly low. In the United States, less than half of those who suffer from mental illness receive treatment for it.[3] Suicide is the 10th leading cause of death in the United States[4] and the second leading cause of death in the world among 15 to 29 year-olds.[5]

Very likely, the taboo of mental illness hinders medical treatment and likely hinders our legal work with clients. In my initial client meetings, I used to ask if there are *any* underlying health issues. My clients would often groan and then proceed to chronicle a litany of illnesses from high blood pressure and diabetes to arthritis and atrial fibrillation. In fact, many of my clients would joke that they never should have retired, because now they just spend all their time in doctors' offices. There's no feeling of embarrassment or shame in these discussions of what might be considered more "traditional" and socially acceptable ailments.

But clients almost never volunteer any history of mental health struggles. No groans and moans about episodes of mania, paranoia or crippling depression or anxiety. For our part, as planners, we can help in this area by specifically asking about mental health issues in our client meetings. By matter-of-factly asking about any history of mental illness, we can try to help normalize it, keeping shame at bay and creating a trusting environment for clients to share their struggles in this area. We can then brainstorm with our clients about how to plan in the event of a future mental health episode. In doing so, we can help our clients come to understand that they're entitled to control their mental health care.

Overview of PADs

A PAD can take many forms, but will typically include:



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1. The individual authorized to make psychiatric decisions in the event of an episode;
2. The preferred hospitals and providers;
3. Effective treatment therapies and medications to be administered; and
4. Ineffective therapies and medications that aren't to be administered.

A fully developed PAD can serve as both a medical history of the patient and informed consent for future treatment. It equips the authorized agent with clear and convincing evidence of the principal's wishes, thus allowing the agent a means to advocate for specific care. With current medical research showing a strong correlation between early intervention and better health outcomes, especially in the area of psychosis, a PAD could truly be lifesaving.[6]

The question then becomes how do we create a legally enforceable mental health directive? Some states have enacted PAD-specific statutes.[7] Other states have broad general health care directive statutes that allow a principal to create an advance directive relating to any type of health care decision.[8] And internationally, at least one country offers a combination financial and health care power of attorney, which includes a section specific to psychiatric treatment.[9]

For the states that have passed legislation specific to mental health, there are unique aspects to each of these statutes, not the least of which relates to binding treatment directives. Such provisions have come to be known as "Ulysses" clauses, in reference to the Homeric hero who wanted to hear the Siren's singing but knew he risked not being able to resist the call of the siren that would lead to crashing his ship. To avoid this catastrophe but still hear the Siren's singing, Ulysses directed his crew not to listen to him at that moment and to keep sailing, even if it were against anything he directed them to do later.

The Nebraska legislature describes the need for mental health specific directives, as well as binding Ulysses provisions, in the legislative intent section of its PAD statute:

> (a) Issues implicated in advance planning for end-of-life care are distinct from issues implicated in advance planning for mental health care;
>
> (b) Mental illness can be episodic and include periods of incapacity which obstruct an individual's ability to give informed consent and impede the individual's access to mental health care;
>
> (c) *An acute mental health episode can induce an individual to refuse treatment when the individual would otherwise consent to treatment if the individual's judgment were unimpaired*[10] (emphasis supplied).

One of the most controversial parts of PADs, and possibly why they haven't been adopted widely by the medical or legal community, is the ability of the principal to refuse or require certain therapies at a later point in time. The medical community may fear that patients will use PADs to prohibit administration of medication that will help providers treat a patient. The legal community may fear PADs will be used to deprive their clients of their civil liberties by waiving their right to refuse treatment.

PADs can at least guide the treatment team so that the providers aren't acting blindly in a way that doesn't honor their patients' preferred treatment modalities.

This tension plays out in the statutes themselves. Consider Pennsylvania's PAD statute, wherein the legislature expresses its intent to create a way for "*competent adults to control their mental health care*" but then limits this right by defining it as a "*qualified right* to control decisions."[11] These statutes have a way of bestowing control and hedging that same control within mere sentences of each other.

To be fair, lawmakers need to balance the interests of the individual and the state. If an individual presents as a danger to self or others, that individual doesn't have an unfettered legal right to harm

Psychiatric Advance Directive Statutes

Comparison of three states

State	Capacity to create psychiatric advance directive (PAD)	Psychotropic medication refusal	Psychotropic medication request	Treatment team override	Revocation by principal	Execution requirements
Kentucky[1]	Principal able to create PAD as long as "right to make health care decisions or to execute legal documents has not been limited"	Allowed as long as an entire class of medications isn't prohibited	Allowed, but elsewhere states that PAD can't "override the grantor's right under federal and state law to refuse treatment"	Allowed by court order or if danger to self or others	Allowed in writing, verbally or by destroying document	Two witnesses and notary; witness and notary can't be health care providers or facility owner, operator, employee or relative of same
Nebraska[2]	Principal has right to create PAD "unless subject to a court order involving mental health care under any other provision of law"	Allowed	Allowed	Silent on override ability but provides immunity to providers acting in accordance with PAD	Allowed at any time unless principal lacks capacity and waived right to revoke in PAD	Two witnesses and notary; notary can't be agent; witness can't be physician or part of treatment team or relative or "romantic" partner or agent or facility owner, operator or employee or relative of same
Pennsylvania[3]	Capacity must be assumed unless (1) adjudicated incapacitated; (2) involuntarily committed; or (3) after examination, one psychiatrist and one other physician or psychologist, preferably one treating principal, declare principal to be incapacitated	Allowed	Allowed	Allowed if terms violate accepted clinical or medical standards of care	Allowed unless lack capacity; also PAD expires automatically every two years unless principal incapacitated at end of two-year period	Two witnesses and can't be treatment provider (and if need help executing, individual signing on behalf of principal also can't witness)

Endnotes

1. Kentucky Advance Directive for Mental Health Act, KRS Chapter 202A Sections 1-7.
2. Advance Mental Health Care Directives Act, NE Rev. Stat. 30-4401 to 30-4415.
3. Mental Health Care, 20 Pa. Con. Stat. 5801-5808.

— Moira S. Laidlaw

themself or others. Hence, the "qualified right" language. PADs, though, can at least guide the treatment team so that the providers aren't acting blindly in a way that doesn't honor their patients' preferred treatment modalities. To understand more about PADs and how they might be able to help your client, "Psychiatric Advance Directive Statutes," this page, compares three different states' PAD statutes and how they balance the interests of patient control, protect against patient coercion and preserve the right of the state to prevent harm to self or others.

Before considering a state's PAD statute, address capacity standards, because providers may question during an episode whether the individual presenting with serious mental illness had capacity at the time of execution of the PAD. In general, legal capacity to execute a health care proxy is the ability to understand the nature and consequences of the medical decisions or directives set forth in it.[12] Capacity should be assumed.[13] Each of the statutes referenced

in the chart on the prior page tackles this issue of capacity and when capacity can't be assumed, and so the chart leads with this issue and then follows with what can and can't be done in a PAD.

Each of the statutes in the chart allows an individual to create a PAD, subject to certain restrictions for those deemed to lack capacity. The statutes also protect providers and state interests by creating room for the treatment professionals to follow standards of care and override directives when necessary. But at least with a PAD in place, the treatment team is provided with a history of effective and ineffective past therapies and can potentially reach a better care plan sooner.

Implementation Strategies

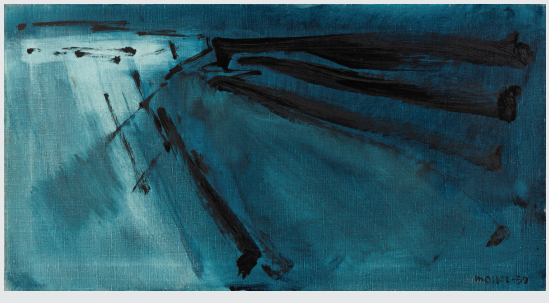
To incorporate PADs into a planning practice, consider the following implementation strategies:

Gain familiarity with local law on health care directives and mandatory involuntary treatment. To incorporate PADs into an estate-planning practice, practitioners need first to familiarize themselves with their local law on health care directives and PADs. As described above, every jurisdiction differs. Some states may have a PAD-specific statute while others may have broad health care advance directive statutes that allow for broad patient expressions of health care preferences. If the state has a PAD statute, familiarize yourself with its specific requirements, especially relating to execution of the instrument, because PAD statutes are stricter with eligible individuals for witnessing than most general advance directive statutes. In addition to reviewing the advance directive law relating to PADs, practitioners also need to review the rules on capacity, as well as those relating to involuntary treatment. One resource in this area may be your local or state bar association, which may offer continuing legal education in the area of mental health law.

Create a PAD template consistent with state law. Luckily, in the area of PAD template development, many resources abound. If local law provides for a PAD-specific statute, these laws will often include a sample form PAD at the end of the statute. If local law allows for a PAD in a more general health care proxy statute, then consider "Sample Psychiatric Advance Directive," pp. 46-47, and review other non-profit resources and the statutory recommended forms in other jurisdictions to come up with the terms you think clients will most want in any PAD.[14]

> One aspect to episodic mental illness is that the serious illness or death of a caretaker can be a triggering event.

Start asking about mental health issues for clients and their beneficiaries. Once armed with the law and a PAD template, in your initial client meetings start asking clients specifically about mental health issues. My most heartwarming conversation in this area was with a couple that shared with me their child's history of bipolar illness, the support they were able to provide to him whenever medication therapy needed to be managed in a different way, which would lead to a temporary decompensation and then restabilization and how their experience with their child led them to fundraise to create a small psychiatric residential treatment facility in their home country, where access to such supportive mental health treatment was nearly



SPOT LIGHT

Underwater

Blue Coast by Hans Moller sold for $2,000 at Swann Auction Galleries Contemporary Art Sale on June 10, 2021 in New York City. German-born Moller emigrated to the United States in 1936, where he worked both as an artist and graphic designer. His time out on Monhegan Island in Maine served as an inspiration for his richly colored abstract landscapes.

Sample Psychiatric Advance Directive

Requirements will vary from state to state

I,_____ being of sound mind, residing at _____, telephone number_____, voluntarily make this directive to authorize a health care agent to make decisions on my behalf regarding my mental health treatment when I lack the capacity to do so. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I had the capacity to do so.

I hereby appoint the following individual as my Primary Mental Health Care Agent ("Mental Health Care Agent") to make any and all mental health care and treatment decisions for me, when and if I become unable to make my own mental health care and treatment decisions as authorized in this document. This person is to be notified immediately of my admission to any hospital or facility wherein I am offered and/or provided psychiatric care.

AGENT 1 NAME: _____
AGENT 1 ADDRESS: _____
AGENT 1 TELEPHONE NUMBER: _____
RELATIONSHIP: _____

If _____ is unable, unwilling or unavailable to act as my Mental Health Care Agent, I hereby appoint the following individual as my alternate Mental Health Care Agent ("alternate Mental Health Care Agent") to make any and all mental health care and treatment decisions for me, except to the extent that I state otherwise.

AGENT 2 NAME: _____
AGENT 2 ADDRESS: _____
AGENT 2 TELEPHONE NUMBER: _____
RELATIONSHIP: _____

A. INSTRUCTIONS REGARDING MY MENTAL HEALTH CARE AND TREATMENT

1. **The following words describe me when I am feeling well:**
_____

2. **The following signs and symptoms will indicate that I am in a mental health crisis:**
_____

3. **Medications/supplements/over-the-counter** medicine **I am currently taking:**

a. Medication / Dosage:_____Reason: _____
b. Medication / Dosage:_____Reason: _____

4. **Medications for psychiatric treatment**: If it is determined that I am not legally capable of consenting to or refusing medications relating to my mental health treatment, my wishes are as follows:

(a) I prefer to be given the following medications:

a. Medication:_____Reason: _____
b. Medication:_____Reason: _____

(b) I prefer not to be given the following medications, for the following reasons:

a. Medication:_____Reason: _____
b. Medication:_____Reason: _____

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5. **Treatment facilities.** I authorize my Mental Health Care Agent to admit me to a hospital for inpatient psychiatric treatment or an outpatient partial hospitalization program. The following are my instructions:

a. I would prefer to receive this care at the following hospitals or programs/facilities, if possible:
_____

b. I prefer not to receive this care at the following hospitals or programs/facilities, if possible, for the reasons I have listed:

Facility: _____

Reason: _____

c. My choice of treating physician, if possible, is:

_____ Phone # _____
OR
_____ Phone # _____

d. I do not wish to be treated by the following physicians, if possible, for the reasons stated:

Dr.'s Name: _____ Reason: _____

6. In the event that I am in a mental health crisis, please contact the following person(s) in addition to my primary Mental Health Care Agent and alternate Mental Health Care Agent appointed herein:

a. Name: _____ Relationship: _____ Phone: _____

b. Name: _____ Relationship: _____ Phone: _____

7. **Additional instructions regarding my mental health care**: (e.g., individual psychotherapy, group therapy, electroconvulsive therapy, self-help services, research):
_____

B. IMPORTANT INFORMATION IF I AM HOSPITALIZED

1. I wish to provide the following information regarding my current mental health care and treatment and to state my preferences regarding mental health care and treatment, in the event I am hospitalized. I strongly hope that my stated preferences will be honored to assist me in having more control over my life and to aid in my treatment.

a. **My Physician and/or Psychiatrist's name and address**:
_____

b. **My outpatient Mental Health Care Provider(s):**
_____

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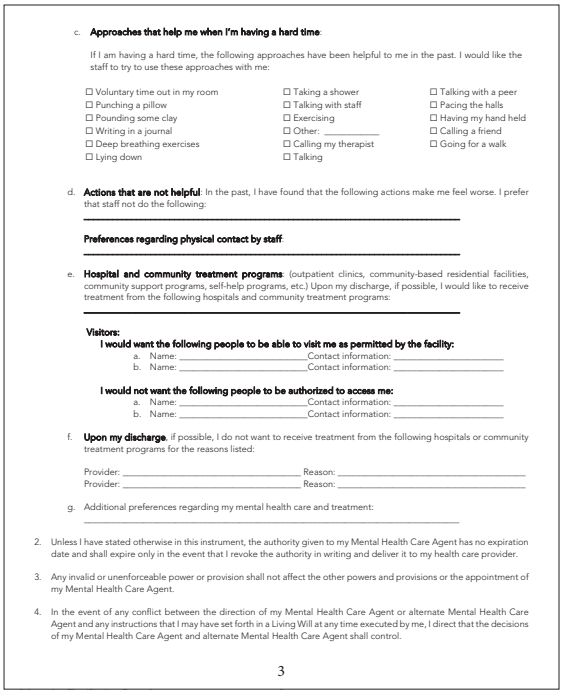
wholly unavailable. I would have learned none of this if I hadn't ask whether they or any family members struggle with mental illness. In these conversations, as part of how I introduce this topic, I'll often talk about the prevalence of mental health issues and how most families, including my own, have some struggles in this area. I do this as a way to develop trust and remove some of the stigma that may block a client from sharing mental health struggles.

One aspect to episodic mental illness is that the serious illness or death of a caretaker can be a triggering event. Helping our clients who are serving in those caretaker roles develop resources and supports ahead of time for any of those in their lives that suffer from episodic mental illness could be one way to make a later illness or death less frightening for those relatives and less of a triggering event. Often in our client meetings, we may be working with those supportive caretakers, not the primary individual who needs a PAD. In those instances, our role may be more about educating clients about PADs and their ability to support their loved ones when they no longer may be able to advocate for them.

Include the clients' providers in the engagement. Unlike many of our advance directives, such as health care proxies and living wills, PADs will vary significantly from engagement to engagement, and each client's PAD will be unique to them. To help with this tailoring, the client's providers need to play a critical role. In addition to making sure that medications and dosages are properly documented, their involvement will buttress enforceability of the PAD in two ways: (1) standards of care; and (2) capacity.

When possible, have a provider sign a letter of capacity contemporaneous with the client's execution of the PAD to buttress later enforceability.

Spread the word about PADs. In the area of trusts and estates, in which many of our legal instruments such as trusts and wills are rooted in centuries-old common law, the ability to use a new legal



c. **Approaches that help me when I'm having a hard time**:

If I am having a hard time, the following approaches have been helpful to me in the past. I would like the staff to try to use these approaches with me:

☐ Voluntary time out in my room	☐ Taking a shower	☐ Talking with a peer
☐ Punching a pillow	☐ Talking with staff	☐ Pacing the halls
☐ Pounding some clay	☐ Exercising	☐ Having my hand held
☐ Writing in a journal	☐ Other: _____	☐ Calling a friend
☐ Deep breathing exercises	☐ Calling my therapist	☐ Going for a walk
☐ Lying down	☐ Talking	

d. **Actions that are not helpful**: In the past, I have found that the following actions make me feel worse. I prefer that staff not do the following:

_____

Preferences regarding physical contact by staff:

_____

e. **Hospital and community treatment programs**: (outpatient clinics, community-based residential facilities, community support programs, self-help programs, etc.) Upon my discharge, if possible, I would like to receive treatment from the following hospitals and community treatment programs:

_____

Visitors:

I would want the following people to be able to visit me as permitted by the facility:

a. Name: _____Contact information: _____
b. Name: _____Contact information: _____

I would not want the following people to be authorized to access me:

a. Name: _____Contact information: _____
b. Name: _____Contact information: _____

f. **Upon my discharge**, if possible, I do not want to receive treatment from the following hospitals or community treatment programs for the reasons listed:

Provider: _____ Reason: _____
Provider: _____ Reason: _____

g. Additional preferences regarding my mental health care and treatment:

_____

2. Unless I have stated otherwise in this instrument, the authority given to my Mental Health Care Agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

3. Any invalid or unenforceable power or provision shall not affect the other powers and provisions or the appointment of my Mental Health Care Agent.

4. In the event of any conflict between the direction of my Mental Health Care Agent or alternate Mental Health Care Agent and any instructions that I may have set forth in a Living Will at any time executed by me, I direct that the decisions of my Mental Health Care Agent and alternate Mental Health Care Agent shall control.

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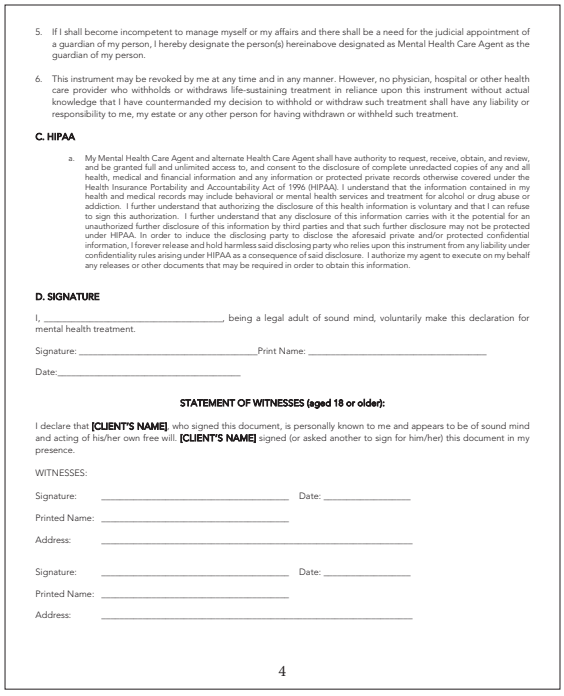

5. If I shall become incompetent to manage myself or my affairs and there shall be a need for the judicial appointment of a guardian of my person, I hereby designate the person(s) hereinabove designated as Mental Health Care Agent as the guardian of my person.

6. This instrument may be revoked by me at any time and in any manner. However, no physician, hospital or other health care provider who withholds or withdraws life-sustaining treatment in reliance upon this instrument without actual knowledge that I have countermanded my decision to withhold or withdraw such treatment shall have any liability or responsibility to me, my estate or any other person for having withdrawn or withheld such treatment.

C. HIPAA

a. My Mental Health Care Agent and alternate Health Care Agent shall have authority to request, receive, obtain, and review, and be granted full and unlimited access to, and consent to the disclosure of complete unredacted copies of any and all health, medical and financial information and any information or protected private records otherwise covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that the information contained in my health and medical records may include behavioral or mental health services and treatment for alcohol or drug abuse or addiction. I further understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that any disclosure of this information carries with it the potential for an unauthorized further disclosure of this information by third parties and that such further disclosure may not be protected under HIPAA. In order to induce the disclosing party to disclose the aforesaid private and/or protected confidential information, I forever release and hold harmless said disclosing party who relies upon this instrument from any liability under confidentiality rules arising under HIPAA as a consequence of said disclosure. I authorize my agent to execute on my behalf any releases or other documents that may be required in order to obtain this information.

D. SIGNATURE

I, _____, being a legal adult of sound mind, voluntarily make this declaration for mental health treatment.

Signature: _____Print Name: _____

Date:_____

STATEMENT OF WITNESSES (aged 18 or older):

I declare that **[CLIENT'S NAME]**, who signed this document, is personally known to me and appears to be of sound mind and acting of his/her own free will. **[CLIENT'S NAME]** signed (or asked another to sign for him/her) this document in my presence.

WITNESSES:

Signature: _____ Date: _____

Printed Name: _____

Address: _____

Signature: _____ Date: _____

Printed Name: _____

Address: _____

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instrument to support our clients is an exciting development. PADs aren't known to many in our field. Now that you know more about them, be sure to share with others this way to meaningfully support clients' control of their mental health care.

— The author wishes to acknowledge Rachel Schneider, a law student at Notre Dame Law School in Notre Dame, Indiana, for her research support.

Endnotes

1. *See, for example*, NY MHL Sections 9.01 and 9.27.
2. Substance Abuse and Mental Health Services Administration, "2019 National Survey on Drug Use and Health."
3. Substance Abuse and Mental Health Services Administration, "National Survey on Drug Use and Health," 2008-2015.
4. Kenneth D. Kochanek, Jiaquan Xu and Elizabeth Arias, *Mortality in the United States, 2019,* NCHS Data Brief. No. 395 (December 2020).
5. World Health Organization.
6. Lana Saad Abdul Jabar, Holger Jelling Sørensen, Merete Nordentoft, et al., "Associations between duration of untreated psychosis and domains of positive and negative symptoms persist after 10 years...," *Schizophrenia Research, https://doi.org/10.1016/j.schres.2020.11.027.*
7. *See, for example*, Mental Health Care, 20 Pa. Con. Stat. 5801-5808.
8. *See, for example*, NY PHL Section 2981(5)(b); *see also* Ronna Blau, Lisa Volpe, Christy Coe and Kathryn Strodel, "Psychiatric Advance Directives: A New York Perspective," *NYSBA Health Law Journal* (Spring 2017).
9. Israel Guardian and Custodianship Law (1962), as amended.
10. Advance Mental Health Care Directives Act, NE Rev. Stat. 30-4402(a)-(c).
11. 20 Pa. C.S. Section 5803(a) and (c), emphasis added.
12. *See, for example*, NY PHL Section 2980(3).
13. *See, for example*, Mental Health Care, 20 Pa. Con. Stat. 5807(a)(1).
14. *See* National Resource Center on Psychiatric Advance Directives, *www.nrc-pad.org*, and the Bazelon Center for Mental Health Law, *www.bazelon.org/our-work/mental-health-systems/advance-directives*, for additional information and resources on psychiatric advance directives.

callout

callout