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, living 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. 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. 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. Suicide is the 10th leading cause of death in the United States and the second leading cause of death in the world among 15 to 29 year-olds.

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 unimpaired10 (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
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.

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.

Endnotes


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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
wholly unavailable. I would have learned none of this if I hadn’t asked 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 requirement...
Committee Report: Elder Care/Special Needs

Preferences regarding physical contact by staff:

Hospitaal 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 programs for the reasons listed:

Provider: _______________________________________ Reason: _________________________________________
Provider: _______________________________________ Reason: _________________________________________
Provider: _______________________________________ Reason: _________________________________________

Additional preferences regarding my mental health care and treatment:

HHoossppiittaall _________________

☐ Deep breathing exercises
☐ Writing in a journal
☐ Punching a pillow
☐ Calling my therapist
☐ Talking with staff
☐ Taking a shower
☐ Having my hand held
☐ Pacing the halls
☐ Talking with a peer
☐ "SHHHHHH"

Address: ____________________________________________________________________

Signature: _________________________________________ Date: ___________________

WITNESSES:

Name: ____________________________Contact information: ________________________

Name: ____________________________Contact information: ________________________

Name: ____________________________Contact information: ________________________

In the event of any conflict between the decisions of my Mental Health Care Agent or alternate Mental Health Care Agent and any instruction that I may have written in this instrument without actual knowledge that I have countersigned the decision to withhold or withdraw such treatment shall have any liability or responsibility to me, my relative or any other person for having withheld or withdrawn such treatment.

C. PAPA.

a. My Mental Health Care Agent and alternate Mental Health Care Agent shall have authority to request, receive, store, and access any and all medical information and resources on psychiatric advance directives. The following basic rules apply to the request for an update or a change to a psychiatric advance directive from a health care provider who withholds or withdraws life-sustaining treatment in reliance upon this instrument without actual knowledge that I have countersigned my decision to withhold or withdraw such treatment shall have any liability or responsibility to me, my relative or any other person for having withheld or withdrawn such treatment.

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

I declare that [CLIENT’S NAME], who signed the instrument, is personally known to me and appears to be of sound mind and acting of his/her own free will.

WITNESSES:

Signature: ____________________________ Print Name: ____________________________

Date: ____________________________

Address: ____________________________

Signature: ____________________________ Print Name: ____________________________

Date: ____________________________

Address: ____________________________

Signature: ____________________________ Print Name: ____________________________

Date: ____________________________

Address: ____________________________

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“ 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.


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 298A(5).


Endnotes

1. See, for example, NY MHL Sections 9.01 and 9.22.

2. Substance Abuse and Mental Health Services Administration, “2019 National Survey on Drug Use and Health.”


5. World Health Organization.

6. Lana Saad Abdul Jabar, Holger Jelling Sørensen, Merete Nordentoft, et al., 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. ☙

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