

## Analysis of State Laws

### WHAT ARE ADVANCE DIRECTIVES?

An advance directive is a written document, made pursuant to legal requirements defined by state law, in which an individual specifies in advance choices about health care treatment in the event that he or she becomes incapable of exercising or communicating such treatment choices in the future.

Every state has enacted some form of statute providing a mechanism for clearly and formally expressing health care choices in such a written directive. While federal law does not require such statutes, Congress noted their importance in the Patient Self-Determination Act.<sup>1</sup> This law requires that any service provider participating in the Medicaid or Medicare programs must inform patients about the state's law concerning advance directives.

There are two principal types of advance directives: an instructional directive and a proxy directive.

◆ An *instructional directive* sets out in written form the person's desires about treatment. Many people are familiar with "living wills" used in end-of-life situations, and most states that recognize them require that the instructions be followed by health care providers.

◆ A *proxy directive*, also known as a durable power of attorney or health care proxy, may include specific instructions but also appoints an agent, or attorney-in-fact, to act in place of the individual when the individual is not capable of making or expressing health care decisions. A proxy directive is usually not triggered until the person is determined, ordinarily by his or her treating physician, to be incapacitated. When that happens, the directive goes into effect, and the agent then is empowered to act in place of the incapacitated individual.

In most states, if the written proxy directive includes instructions to the agent, the agent must follow those instructions. If the directive does not include instructions, the agent may be required to employ a substituted judgment test or to act in what the agent determines to be the individual's best interest. Health care providers are usually required by the state's law to follow the instructions of an agent acting pursuant to an advance health care directive.

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Most state laws include a list of elements that must be in an advance directive, and many include suggested forms. In most cases, written directives may be followed even when precise formalities are not followed. A New York state case, *In re Rosa M.*,<sup>2</sup> upheld an advance directive by a patient refusing treatment with electroconvulsive therapy even though the written directive did not comply with the statutory form.

Most of the state advance directive statutes expressly or by implication apply to mental health care. A dozen or more states, however, have also enacted advance directive statutes that apply specifically and solely to at least some kinds of mental health treatment.

## ADVANCE DIRECTIVES IN SELECTED STATES

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A review of every state law was beyond the scope of this project. We therefore focused on the laws in four target jurisdictions: New York, North Carolina, Nebraska and Washington D.C.<sup>3</sup> (Of these, only North Carolina has a state law specifically for advance decisionmaking for mental health care.) In this section we also include discussion about Vermont and Washington state laws, where recent legislative activity particular to psychiatric advance directives has occurred.

Relatively few judicial opinions address the legality and enforceability of psychiatric advance directives *per se*, but several legal issues have emerged as key considerations for determining whether consumers in a particular jurisdiction can utilize advance directives for mental health decisions in a meaningful way. When reviewing a state law, we focused on the following questions:

- ◆ Does the law address only advance directives for mental health care, or does it cover other health care decisions?
- ◆ What conditions trigger an advance directive when it is used for mental health care decisions? (When does it spring into effect?)
- ◆ Does the law provide for any limits on a provider's obligation to follow mental health treatment decisions made in an directive or made by an agent appointed as a health care power of attorney? Included in this issue are connections between the laws governing advance directives in a jurisdiction and the laws related to emergency detention and involuntary commitment (outpatient or inpatient).
- ◆ What, if any, limits are placed on the authority that a mental health consumer can assign to an agent through an advance directive?
- ◆ What consequences, if any, flow from a provider's failure to honor or comply with decisions expressed in an advance directive?
- ◆ How can advance directives be revoked or changed?
- ◆ If the law is specific to psychiatric advance directives, how do its provisions (particularly those described above) relate to the jurisdiction's more general advance directives laws?

## NEW YORK

New York's law on "Health Care Agents and Proxies"<sup>4</sup> covers all types of health care decisionmaking. Under the New York scheme, an individual has the power to appoint a health care agent to make decisions when the attending physician determines that the person is unable to make health care treatment decisions. If the inability to make decisions is based on mental illness, "the attending physician . . . must consult, for the purpose of confirming the determination, with a qualified psychiatrist" and record the determination in the medical record.<sup>5</sup>

New York does not have a specific law allowing an individual to provide instructions about treatment and express attitudes and wishes about health care, as one would in a living will. The health care proxy law does state, however, that a proxy "may include the principal's wishes or instructions about health care decisions, and limitations upon the agent's authority."<sup>6</sup>

Importantly, the New York law gives continuing precedence to a principal's decisions, even when an attending physician has determined that the individual lacks capacity to make health care decisions. If the principal "objects to the determination of incapacity or to a health care decision made by an agent, the principal's objection or decision shall prevail unless the principal is determined by a court of competent jurisdiction to lack capacity to make health care decisions."<sup>7</sup>

Generally, health care proxies in New York are valid until canceled by the principal. The principal has the option, however, of specifying a particular expiration date or expiration-triggering event.<sup>8</sup>

The New York law allows for revocation of a health care proxy as long as the principal is competent.<sup>9</sup> Accordingly, even when the individual's *capacity* is questionable, the individual may revoke the health care proxy unless a court of law determines that he or she is incompetent to make the decision to revoke. A principal may revoke an advance directive by "notifying the agent or a health care provider orally or in writing or by any other act evidencing a specific intent to revoke the proxy."<sup>10</sup> Execution of a subsequent health care proxy will also revoke an earlier proxy.<sup>11</sup>

Interest in PADs appears to have increased in New York following the November 1999 enactment of the state's Involuntary Outpatient Commitment (IOC) Act.<sup>12</sup> The state legislature found that "the voluntary use of such [health care] proxies should be encouraged so as to minimize the need for involuntary mental health treatment." The law mandates that a court shall take into account any directions included in a health care proxy in determining what will be in a written treatment plan for involuntary outpatient treatment.<sup>13</sup>

The effect of including health care proxies (in effect, PADs) in the legislation is potentially positive. Right after enacting the IOC law, the New York legislature appropriated funds to train consumers and mental health treatment providers about advance directives and their im-

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An important feature of the New York law is the way it gives continuing precedence to a principal's decisions, even when an attending physician has determined that the individual lacks capacity to make health care decisions.

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plications for mental health care decisionmaking. The funds were distributed through the state's Office of Mental Health. Two private organizations were originally funded to develop and implement training

programs. The Resource Center, a peer-run agency, implemented an advance directives training project for consumers, survivors and ex-patients across the state until January 2002,<sup>14</sup> while the New York Association of Psychiatric Rehabilitation Services (NYAPRS) trains community mental health professionals about advance directives. Both groups developed valuable training materials and strategies.<sup>15</sup>

Some advocates and consumers in the state were cautiously optimistic that the attention on advance directives by way of New York's IOC law would promote widespread use of PADs, which could, in turn, work to vitiate the need for IOC itself. Advance directives, if widely utilized, may also be helpful for documenting consumers' desires for services that are not offered or available in the state.

Despite the positive potential, the New York connection between advance directives and IOC might undermine the potential for consumer empowerment if the concept is presented in a coercive context or the tools are used inappropriately. For example, the health care agent or proxy should enter the picture only when the principal is incapable of making his or her own decisions and should not be drawn into treatment decisions at other times.

Prior to passage of the IOC Act, advance directives had faced only one court test in New York, and to date no other published decisions exist on the issue. In the 1999 case, *Matter of Rosa M*,<sup>16</sup> a court refused to order electroconvulsive therapy (ECT) for an incompetent woman who had previously written a statement ("I am withdrawing my consent to electroconvulsive therapy and am refusing any more treatments with this procedure."), even though the statement did not comply with statutory standards.

### Advance Directives for Youth

During the Bazelon Center's three-year project, we were contacted by several parents about the use of advance directives for youth. We've learned in some cases families have informally adapted the Bazelon Center's advance directive template for use by youth as a statement of treatment preferences. While individuals who have not reached the age of majority cannot make legally binding advance directives, we have heard from the field in these instances that the young person's experience of considering the treatment options and completing the form was very positive, consistent with many comments we have gotten from adult consumers.

We suspect that interest in advance directive-style documents may be increasing among youth and their advocates. At least one jurisdiction, New York, has taken hold of this interest in a thoughtful way. The Bureau of Children and Families in the state's Office of Mental Health (OMH) began a consumer-driven project in January 2000 to utilize the concepts behind advance directives for youth, who may not be able to execute a legally binding PAD but might nevertheless benefit from a tool to help them explore treatment options and make their preferences and ideas known in advance of a crisis. OMH developed two tools for youth. First is "My Prime Directive Journal," a booklet of probes with space for teenagers and other youth to express such things as "I fell my best/worst when: "; "The real me is: "; "Someday I'd like to:" and "Ten years from now, I'd like my like to be or not to be:". The second part is "My Prime Directive," a document modeled on an advance directive form and designed to facilitate communication between youth and professionals about their experiences with treatment, the services they are receiving and what they believe they need from the mental health system. The document can also be shared, at the consumer's direction, with parents or others who could appreciate insight into the young person's goals for recovery. Other jurisdictions may look to this as a model. See [www.omh.state.ny.us/omhweb/omhq/a0601/onev0601.html](http://www.omh.state.ny.us/omhweb/omhq/a0601/onev0601.html).

## NORTH CAROLINA

North Carolina has a law that deals specifically with psychiatric advance directives, known as “Advance Instructions for Mental Health Treatment” or AIMHT, N.C.<sup>17</sup> This law was first enacted in January 1998, then amended later that year, as an addition to the state’s general Health Care Power of Attorney Act (HCPOA).<sup>18</sup> Unfortunately, consumers do not seem to have benefitted from the AIMHT. As one local observer explained to us, North Carolina had an “inadequate law, incompetent advocacy resources and a nonexistent education and dissemination plan.” This combination may have dashed hopes for more consumer self-determination in that state, but can serve as useful information for other jurisdictions hoping to promote the use of advance directives.

The original AIMHT statute apparently pleased none of the stakeholders—consumers, medical professionals, legal professionals. Negotiations among consumers, providers and the bar (particularly trusts and estates attorneys) throughout most of 1998 led to compromise legislative amendments, effective in October 1998. However, the law remains seriously flawed.

One of the more significant problems is a list of conditions under which a mental health provider is permitted to override an advance instruction document. The list is so broad that it is unlikely that a physician or other mental health provider will ever feel compelled to honor an advance instruction if he or she is not otherwise inclined to do so. The statute lists four conditions that allow the attending physician “or other mental health treatment provider” to disregard all or any part of an advance directive. These conditions include:

- ◆ The AI is not consistent with generally accepted community practice standards of treatment to benefit the principal.
- ◆ The AI is not consistent with the availability of the treatments requested.
- ◆ Compliance, in the opinion of the attending physician or other mental health provider, is not consistent with appropriate treatment in case of an emergency endangering life or health.

These conditions weaken the law in several respects. The meaning of “not consistent with the availability” is not defined in the statute and is ambiguous. Conceivably, the phrase could refer to economic or geographic availability or inadequate numbers of trained staff. Further, the statute does not obligate providers to seek an acceptable treatment substitute if they do not follow the advance instructions. Additionally, “mental health provider” is not defined, which means the statute may be read to give override authority to individuals who are not qualified to make such medical determinations. Furthermore, while an exception for emergency treatment is not unique to North Carolina’s statutory scheme, this exception is not narrowly tailored to allow for only what is necessary to avert serious harm.

As for revocation, the AIMHT law originally included a two-year

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expiration of the advance instruction, which was not suspended by a principal’s incapacity. The revised statute, in effect, removes the expiration clause, and allows for revocation by the principal as long as he or she is not incapacitated. Since an AI instrument is triggered upon incapacitation, once activated, it cannot be revoked while in use.

In addition to problems with the NC advance instruction law itself, its provisions do not work easily with other state laws. The general HCPOA<sup>19</sup> provides that a health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, but doing that may not be so easy. Under the general statute, if an advance instruction exists, the health care agent’s decisions about mental health treatment shall be consistent with any statements the principal has expressed in the AI. If no advance instruction exists, the agent’s decisions are to be consistent with what the agent believes in good faith to be the manner in which the principal would act if the principal did not lack sufficient understanding or capacity to make or communicate health care decisions. The form included in the general HCPOA statute, however, applies one standard of care for an agent’s decisions about physical health care (“use due care to act in the principal’s best interests and in accordance with this document”) and another standard for making decisions about mental health care (“health care agent will act according to how the health care agent believes you would act if you were making the decision”).<sup>20</sup>

Some legal professionals in the state also believe that the general HCPOA statutory form, as it existed, would have been stronger and could have been used more easily in connection with an AI had the AIMHT been incorporated into it by reference. The form that was used prior to the 1998 amendments was general and did not include references to specific illnesses. Reportedly, many attorneys prefer the earlier version, and they continue to advise their clients to use it.

Despite its shortcomings, the statute has positive features. Among these is the requirement of documentation for noncompliance. The attending physician or “other mental health care provider” must promptly notify the principal if he or she will not honor the preferences in an advance directive. Also, the provider must document in the medical record both the notification and the reason for not complying. Such documentation may be useful for analyzing the effectiveness of advance directives. At present, however, it has limited use because usage of advance instructions is not being tracked in North Carolina.

For the reasons described above, the North Carolina law is not a strong model for consumer rights, and even its limited potential seems to have been squandered. It is our understanding that shortly after the AIMHT law was passed in 1998, the local chapter of the National Alliance for the Mentally Ill (NAMI N.C.) and the North Carolina Mental Health Consumers Organization (NCMHCO) had conference workshops and presented information about the AIMHT. In contrast to what

has happened in New York, however, it appears that no one in the state ever developed a statewide strategy for continuing the education or promotion of advance directives, and no organization or group has taken on the responsibility for this type of activity. With no champion, opportunities for promoting the advance directives concept and possibly improving the law seem to have been lost.

#### WASHINGTON D.C.

Consumers and advocates in the District of Columbia have been very interested in promoting the use of advance directives for psychiatric care on a widespread scale since at least 1997. However, they faced a major hurdle: the public mental health system had announced its legal position that advance directives for psychiatric treatment—unlike those for other medical care—were unenforceable under District law.<sup>21</sup> As a result, providers in the public mental health system and consumers who relied on the system for services were told that psychiatric advance directives need not, and would not, be honored if presented at St. Elizabeths Hospital (the public psychiatric hospital), the city's emergency psychiatric response division or any of the community mental health centers in the public system.

In early 2000, however, following the federal court's appointment of a transitional receiver to run the public system,<sup>22</sup> this interpretation changed dramatically. The new public mental health authority, the D.C. Department of Mental Health, recognizes the legality of advance directives for mental health care decisions under D.C. law.

The current legal basis for psychiatric advance directives in D.C. is the Health Care Decisions Act of 1988 (HCDA)<sup>23</sup> and the Mental Health Service Delivery Reform Act of 2001, the law setting up a Department of Mental Health pursuant to federal court order. Accordingly, D.C. has a general law but specifically clarifies its applicability to mental health care decisions.

The Mental Health Consumers' Rights Protection Act of 2001<sup>24</sup> expressly recognizes that "[a]ll consumers may execute a durable power of attorney for health care in accordance with the 'Health Care Decisions Act of 1988'" and it strengthens the general HCPOA provisions as they apply to mental health decisions. The law states that a "durable power of attorney for health care may include a statement of the consumer's mental health treatment preferences, which shall be honored by his or her attorney-in-fact or by any substitute health care decision-maker in accordance with D.C. Code § 21-2210(b)."<sup>25</sup> Moreover, "[t]he consumer's treatment preferences shall be followed by the Department or other provider except for good cause as documented in the consumer's clinical records, and shall never be overridden for the convenience of the Department or other provider."<sup>26</sup>

The HCDA provides that "[a] competent adult may designate, in writing, an individual who shall be empowered to make health-care

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decisions on behalf of the competent adult, if the competent adult becomes incapable, by reason of mental disability, of making or of communicating a choice regarding a particular health-care decision..."<sup>27</sup> An agent may have the authority "to grant, refuse or withdraw consent on behalf of the patient with respect to the provision of any health-care service, treatment or procedure,"<sup>28</sup> with the exception of psychosurgery, ECT and behavior modification programs.<sup>29</sup>

As to revocability, the Health Care Decisions Act provides that at any time the principal has the capacity to make a durable power of attorney, he or she may revoke it, and it includes a rebuttable presumption that a principal has the capacity to revoke the durable power of attorney.<sup>30</sup> In other words, it is presumed, absent other evidence, that a principal has the capacity to revoke when he or she takes steps to do so. It is not clear from the law exactly where the limit on revocability falls, but the statutory form states that a principal may take away the authority of an attorney in fact, "unless [the principal has] been adjudicated incompetent."<sup>31</sup>

The basis of the new law is that no mental health services or supports shall be provided without a consumer's informed consent.<sup>32</sup> When a consumer's physician believes that the consumer is incapable of making a decision, the physician must seek a certification of incapacitation in accordance with the Health Care Decisions Act, which will activate an advance directive if such a document has been created by the consumer.<sup>33</sup>

Through the new mental health law, the District of Columbia has also addressed some of the concerns that providers and consumers have expressed about how advance directives relate to obligations and rights that arise during mental health emergencies or involuntary commitment proceedings. Generally, only the particular mental health services and supports to which the attorney-in-fact consents shall be provided to a consumer whose PAD has been activated. Limited exceptions to this rule apply during emergency situations. An "emergency" exists "when it is the written opinion of the attending physician that delay in obtaining the consent of the consumer, the attorney-in-fact, or a substitute health care decision-maker is likely to result in serious injury to the consumer or others, and mental health services and supports are delivered only to the extent necessary to terminate the emergency."<sup>34</sup> The law clearly does not allow for a wholesale override of an advance directive just because an individual is subject to involuntary commitment.

The new consumers' rights law also includes a section on the administration of medication, and it clarifies how the provisions in a psychiatric advance directive come into play when forced medication is proposed.<sup>35</sup> Here, again, the overarching principle is that medication may only be administered with the consumer's informed consent. If the consumer has been certified as incapacitated, his or her attorney-

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in-fact or substitute health care decision-maker may consent to the administration of medication only in accordance with the consumer's treatment preferences, as expressed in a durable power of attorney or declaration of advance instructions for mental health treatment.<sup>36</sup> Except in an emergency, as discussed above, a provider may administer medication to an incapacitated individual without such informed consent *only* after following a prescribed administrative procedure, which includes a right to advocacy representation, a review of the medication recommendation by a neutral party (who may order no more than 30 days of involuntary administration of medication) and the right of appeal of the decision to an independent panel.<sup>37</sup>

During the review period of our study, neither the new legal position of the public mental health system nor the provisions about mental health care decisionmaking in the new consumer rights law led to an increase in the use of advance directives by consumers in the District of Columbia. Whether the system and local advocates will promote the use of these tools in a way similar to the New York approach or continue the *status quo* remains to be seen, given that the law is still new and many changes are underway to create a recovery-oriented mental health system in D.C. that can be operated without court oversight.<sup>38</sup>

## NEBRASKA

For a number of years, the great majority of complaints received by Nebraska's protection and advocacy system, Nebraska Advocacy Services (NAS), focused on alleged inappropriate treatment. Advocates have interpreted the statistic as showing that large numbers of consumers believe they are either prevented from making their own health care decisions or afforded

The state of Maine has become a national leader in recognizing trauma and developing systematic responses to the needs of abuse survivors. The Maine Department of Behavior and Developmental Services (formerly the Maine Department of Mental Health, Mental Retardation and Substance Abuse Services) formed an Office of Trauma Service ("OTS") in 1995 to "increase awareness and knowledge of the prevalence and disabling impacts of interpersonal violence in the lives of children, adolescents and adults served by Maine's public health and human services systems, and to build capacity within the existing (mental health) system to deliver trauma-sensitive services which will assist these individuals in their recovery." Data from the state indicate that the large majority (as high as 70-80%) of mental health consumers in Maine's public mental health system have a history of severe abuse trauma.

OTS developed a "Personal Safety Form," very similar to an advance directive, as one tool to assist consumers and clinicians in collecting relevant information in a sensitive way that fosters clinical recovery. The form is a guide to gathering information that is to be incorporated into treatment planning for the individual. The Personal Safety Form is a key part of the clinical protocol that OTS has developed for the use of seclusion and restraint, aimed at ensuring that when it is necessary to utilize these interventions. It is done based on knowledge of what may constitute a re-traumatizing experience for the consumer and the consumer's own understanding of what helps him or her to de-escalate the crisis.

Among other information, the form asks the consumer to identify what things help when he or she is having a hard time and provides a long list of possibilities to spur thinking in this area (voluntary time out, punching a pillow, exercise, taking a shower, deep breathing, talking with a therapist, etc.). The form also asks about triggers that the consumer knows will cause a crisis to escalate, preferences for alternative interventions if he or she becomes in danger of hurting self or others, preferences in the gender of emergency staff, and information about medications. More information about the program is available through OTS and in their publications, including *In Their Own Words* a 1997 report from trauma survivors and professions they trust about what hurts and what helps when during a crisis. See [www.umaine.edu.sws.ots](http://www.umaine.edu.sws.ots).

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little influence by the mental health providers who are making those decisions for them.

Driven by these views, NAS has been interested in promoting advance directives for psychiatric care since at least 1994. During the mid-1990s, the organization's advisory council made it an agency priority to help build and support a consumer movement in the state. NAS viewed its advance directive work as a way to work toward enhanced consumer self-determination.

Advocates pushed for advance directives on several fronts, first working unsuccessfully for passage of a "mental patients bill of rights" with a reference to advance directives. NAS retooled its efforts in 1997 to promote the use of advance directives among mental health consumers pursuant to existing state law on living wills and health care power-of-attorney documents. In 2000, NAS published "Health Care Power of Attorney: A Manual for Nebraska Advocates," a workbook for consumers and their advocates, and began to train individuals around the state about psychiatric advance directives and assist those who expressed an interest in executing such documents.

Nebraska's advance directive law is a general health care power of attorney law that does not specifically mention mental health care decisionmaking, but also does not exclude it.<sup>39</sup> Under the law, the authority of an attorney-in-fact commences upon a determination that the principal is incapable of making health care decisions.<sup>40</sup> The decision about capacity must be made in writing by the attending physician and any physician consulted with respect to the determination that the principal is incapable, who must document in the medical record the cause and nature of the principal's incapacity.<sup>41</sup> If a dispute arises as to whether the principal is incapable, a proceeding triggering a court determination may be initiated.<sup>42</sup> In certain situations, when a consumer is refusing certain treatments, the decision about incapacity must be made by a judge.

A power of attorney for health care in Nebraska may be revoked at any time by a principal who is competent, and in any manner by which the principal is able to communicate his or her intent to revoke.<sup>43</sup>

Nebraska advocates report that their materials have generated increasing interest in mental health advance directives. State advocates are prepared to defend the legality of advance decisionmaking for mental health care. They also have a plan to monitor or track the use of PADs. As in New York and the District of Columbia—but not North Carolina—the availability of legal advice and counsel to consumers who want to execute advance directives appears to have been helpful in getting a promotion strategy off the ground.

OTHER JURISDICTIONS AND KEY LEGAL ISSUES

◆ **Vermont:**—Permitting people who are not mentally ill to engage in advance planning through advance directive instruments on a wider basis than people with mental illnesses raises significant equity issues. A federal court, reviewing a Vermont law, addressed such an issue.

Vermont has two statutes that allow residents to create advance directives. One allows for “durable powers of attorney for health care”<sup>44</sup> and the other permits creation of “terminal care documents,” commonly referred to as “living wills.”<sup>45</sup> Against this scheme, the state legislature enacted a new law, commonly referred to as “Act 114,” which allows the state to ask a court to override an individual’s advance directive if adherence to it does not result in “significant clinical improvement” within 45 days.<sup>46</sup> There is no comparable procedure allowing the state to seek vitiation of a durable power of attorney for health care of an individual who is not characterized as having a psychiatric disability.

A 1999 class action, *Hargrave v. State of Vermont*, challenged the law as discriminatory under the Americans with Disabilities Act<sup>47</sup> and Section 504 of the Rehabilitation Act.<sup>48</sup> The lead plaintiff, a woman diagnosed with a mental illness and cancer, who had an advance directive in which she expressed preferences against certain treatments for her cancer and against psychiatric medication, was joined by the Vermont protection and advocacy system as plaintiff-intervenor.<sup>49</sup> The state sought to forcibly medicate Ms. Hargrave with psychiatric medication, in a non-emergency situation, in direct contravention of the wishes expressed in her durable power of attorney. Plaintiffs argued that since the only advance directives that can be overridden are those regarding mental health treatment, the law discriminates against people with mental illness and violates the ADA.

In October 2001, a federal trial court ruled that this provision is discriminatory and violates Title II of the ADA, which provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.<sup>50</sup> The court held that:

Although every state has done so, no state is required by federal law to establish a mechanism whereby individuals can articulate prior health care directives to control their medical treatment in the event of a later incapacity. However, once a state creates the opportunity, it [cannot] prevent individuals from establishing the directives and having them accorded the deference inherent in the statute because of their disabilities.<sup>51</sup>

The court rejected the state’s argument that Act 114 did not single out individuals with mental illnesses due solely to their illness, but due to the “dangerousness” caused by their illness.<sup>52</sup> Comparing the rights

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One question raised is whether an advance directive may be used to accomplish a “voluntary admission” to an inpatient facility, where the agent follows written instructions over the principal’s contemporaneous objection to admission.

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of individuals facing physical illness, the court found that:

[A] prior decision to forego medical intervention necessary to sustain life is permitted for the physically ill or disabled, even though at the time of incapacity, rejection of the treatment could be seen as posing a “danger to themselves.” In fact, that is the very purpose behind legislation permitting individuals to execute prior health directives such as Vermont’s DPOA. While there is no provision in Vermont law to compel an incompetent physically disabled individual to undergo treatment in violation of a DPOA, *even if that treatment is needed to save the individual’s life*, the State would have the Court declare that because a mentally ill individual at a particular point poses a danger to herself, her prior wishes to forgo medical treatment calculated to abate the danger can be ignored.<sup>53</sup>

This ruling has been appealed to the Second Circuit. Demonstrating the importance of the issue, 18 former state mental health commissioners and others, including the National Mental Health Association, the International Association of Psychosocial Rehabilitation Services and the American Association of People with Disabilities, filed an amicus brief in support of the right of individuals to inform caregivers of their treatment preferences through the execution of legally enforceable advance directives.

◆ **Washington**—One aspect of debate in Washington state highlights a concern that is likely to resurface in that state and elsewhere: that promising aspects of advance decision-making for mental health—helping consumers get treatments they have found helpful and avoid forced hospitalization and negative or harmful interventions—are potentially subverted when the focus is on getting signers to agree to treatment and commitment and, in effect, to weaken or evade involuntary treatment laws.

Washington state has a generic durable power of attorney for health care statute that does not specifically mention mental health decisions, but allows a principal to authorize an agent to give informed consent for health care decisions on the principal’s behalf.<sup>54</sup> While consumers have executed mental health advance directives pursuant to existing law, proposals for a new and separate mental health advance directives statute have been debated recently in the state. Concerns with the existing law relate to a perceived lack of clarity regarding how it interacts with state guardianship laws and questions regarding the enforceability of mental health care directives.<sup>55</sup> In its 2002 session, the state legislature considered proposals for an advance directives statute that would apply specifically and exclusively to mental health treatment, but none passed.<sup>56</sup>

As various legislative proposals have been considered in Washington, one question raised is whether an advance directive may be used to accomplish a “voluntary admission” to an inpatient facility, where the agent follows written instructions over the principal’s contemporaneous objection to admission.<sup>57</sup> New York and some other jurisdictions limit an agent’s power to authorize voluntary admission to a psychiatric facility, even if made pursuant to an advance directive. This issue will likely receive continued attention in Washington and other states.

## CONCLUSION

Making decisions about health care in the event of future incapacity can be empowering to anyone. Advance planning may be even more important, but also more complex, in the mental health context, where insistence on particular, unwanted options has been the experience for many.

The Bazelon Center’s three-year exploration into the legal and practical issues that are raised by psychiatric advance directives allowed us to look closely at how these tools have been used in four states and to have many conversations with consumers, providers and advocates about the subject.

## NOTES

1 42 U.S.C. §§ 1395cc(f) & 1396a(w)(1994).

2 597 N.Y.S.2d 544 (Sup. Ct 1991).

3 An excellent reference for a more global review of state laws affecting advance directives for mental health care is in Robert D. Fleischner, “Advance Directive for Mental Health Care: An Analysis of State Statutes (1998) (prepared for Advocacy, Training and Technical Assistance Center for the National Association of Protection and Advocacy Systems). This document can be accessed through the Bazelon Center’s website, via [www.bazelon.org/advdir.html](http://www.bazelon.org/advdir.html).

4 N.Y. Pub. Health L. 2980, *et. seq.*

5 See § 2983(1)(b).

6 § 2981(5)(b). The courts in New York have honored living wills when such documents have established a person’s wishes by “clear and convincing proof.” See *Matter of Storar* and *Matter of Eichner v. Dillon*, 52 N.Y.2d 363 (1981). That is, it must be shown that the person who has become incapacitated had previously given clear and specific instructions regarding a certain type of medical care or procedure. New Yorkers who create both types of documents – health care proxy and living will – can thus have instructions for the health care agent that will guide his or her decisions. It is possible, however, that general instructions about refusing treatment, even if written down, may not be effective if they do not meet the “clear and convincing proof” test.

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Advance planning may be even more important, but also more complex, in the mental health context, where consumers face the possibility of losing the capacity to make or communicate treatment decisions and where insistence on particular, unwanted options has been the experience for many.

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7 §2983(5). See also §2989(2): “Nothing in this article creates, expands, diminishes, impairs or supersedes any authority that a principal may have under law to make or express decisions, wishes or instructions regarding health care, including decisions about life sustaining treatment, whether or not expressed in a health care proxy.”

8 §2981(5)(c).

9 §2985.

10 *Id.* at §2985(a).

11 §2985(c).

12 Mental Hygiene Law §§ 9.60 as added by Chapter 408 of the Laws of 1999, commonly known as “Kendra’s Law.”

13 N.Y. Cons. Laws, Mental Hygiene Law §§ 9.60(c)(8).

14 It is our understanding that no group is currently providing consumer training on advance directives in the state.

15 See “Advance Directives for Mental and Physical Health Care in New York State,” by Disability Advocates, Inc. (revised 2/2000), at <http://www.cqc.ny.us/advdi.htm>.

16155 Misc. 2d 103, 597 N.Y.S. 2d 544 (Sup. Ct. 1991).

17 Gen. Stat. at Chapter 122C-71, *et seq.*

18 N.C. Gen. Stat. at Ch. 32A, Article 3, 32A-15, *et seq.*

19 N.C. Gen. Stat. at Ch. 32A, Article 3, 32A-15, *et seq.*

20 See N.C. Gen. Stat. § 32A-25.

21 The City’s attorneys argued that even though the Health Care Decisions Act (HCDA) does not defined “health care,” it governs medical but not psychiatric decisions. In at least one trial court decision, however, a judge specifically found that nothing in the language of the HCDA implies that health care is limited to treatment for physical conditions or excludes treatment for psychiatric conditions. See *In re Gibson*, No. 97-FM-1425.

22 The District of Columbia’s mental health system has been under federal court order since the 1970s, pursuant to the lawsuit now known as *Dixon v. Williams*. The first Receiver was appointed to run the system in November 1997. He was replaced by a “Transitional Receiver” after systemic problems continued, pursuant to a new agreement between the parties.

23 D.C. Code Ann. §§ 21-2201 *et seq.* (1998)

24 Title II, Section 101, *et seq.*

25 See § 106(a).

26 *Id.*

27 §21-2205(a)

28 §21-2210(a)

29 § 21-2211

30 *Id.* at § 21-2208.

31 §21-2207.

32 (§107(a))

33 *Id.* at §107(b)-(c).

34 *Id.* at § 107(c)(3)(A).

35 *Id.* at § 108.

36 §108(b).

37 When the consumer's refusal to consent to medication is made on the basis of a "valid religious objection" such objection may not be overridden without a specific court order. § 108(d).

38 In 1999 and early 2000, under the first receiver's tenure, a format for non-binding documents, entitled Consumer Statement of Treatment Preferences (CSTP), was developed and promoted to a limited degree as a substitute for a legally enforceable advance directive. The CSTP was to be used in treatment planning in the public hospital and throughout the publicly funded community system. While these documents did not meet consumers' desires for legally enforceable advance directives—and reportedly were never widely embraced by consumers or providers—some of the work that the small office of Consumer and Family Affairs did on that project could be of use in advance directive training. Other consumers have been trained to develop Wellness Recovery Action Plans developed by Mary Ellen Copeland under the "WRAP" program used in other jurisdictions, and this peer-run training may also be a launching pad for widespread promotion of advance directives.

39 See Neb. Rev. Stat. § 30-3401 *et seq.* (1992). "Health care" is defined as "any treatment, procedure, or intervention to diagnose, cure, care for, or treat the effects of disease, injury, and degenerative conditions." Neb. Rev. Stat. § 30-3402(4). "Health care decision" includes "consent, refusal of consent, or withdrawal of consent to health care. *Id.* at § 30-3402(5).

40 *Id.* at . §30-3411.

41 *Id.* at § 30-3412.

42 See *id.* at § 30-3415.

43 *Id.* at § 30-3420(1).

44 14 V.S.A. §3451 *et seq.*

45 18 V.S.A. § 5251 *et seq.*

46 18 V.S.A. §7624 *et seq.*

47 42 U.S.C. § 12132.

48 29 U.S.C. § 794

49 A class was certified consisting of "individuals within the state of Vermont who have been or in the future will be diagnosed as having a mental illness and who either have or will execute a durable power of attorney for health care or have been or in the future will be deterred from executing such an advance directive for health care as a result of Act 114."

50 *Hargrave v. State of Vermont*, No. 2:99-CV-128 (D. Vt. Oct. 11, 2001), federal appeal to Second Circuit filed February 2002. This decision can be found on the Bazelon Center's website.

51 *Id.* at 22-23.

52 *Id.* at 24

53 *Id.* at 25-26 (emphasis in original).

54 Wash. Rev. Code 11.94.010(3).

55 It is our understanding that initial legislative proposals for a PAD statute in Washington were a response, at least in part, to concerns of some about legal

### limitations of involuntary hospitalization and treatment

56 All of this activity is taking place while a five-year project to study PADs has been underway in the state. Under the direction of Debra Srebnik, Ph.D. of the University of Washington, the project recruited participants from at least two sites in the state to execute PADs and has begun tracking whether and how those PADs are used/honored during mental health crises. As the project began its third year in April 2002, some of the experiences indicated that additional training within crisis and hospital systems was needed to ensure that working mechanisms were in place for providers to know who has a PAD and to access them at a time of crises. The ultimate findings of the study may well inform future legislative proposals in Washington and other jurisdictions looking at mental health advance directives.

57 At least one Washington proposal in 2002 would have permitted a 72-hour inpatient hold of an individual who executed an advance directive but later wanted to revoke provisions related to inpatient hospitalization, if the revocation was expressed when the individual lacked the capacity required to revoke the directive. The involuntary admission over the contemporaneous objection of the individual could be accomplished without the due process protections of existing involuntary commitment procedures.

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