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Psychiatric Advance Directives: A New York Perspective

By Ronna Blau, Lisa Volpe, Christy Coe and Kathryn Strodel

Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.[1]

I. INTRODUCTION

It is a firmly established principle in New York common law that every individual of adult years and sound mind has a right to determine what shall be done with his own body[2] and to control the course of his medical treatment.[3] Patient autonomy and self-determination are basic tenets of New York law that have been faithfully adhered to by courts[4] and codified in various statutes governing informed consent and health care decision making.[5] The priority of the patient's decision is a firmly ensconced principle in New York State law.[6]

As medical technology advanced it became clear, however, that there was a need for consistent decision making procedures for patients who lost decision making capacity. Beginning with California in 1976, all states enacted advance directive statutes of some sort, including either living wills (containing instructions about particular treatments and medical conditions) or durable powers of attorney (appointing a surrogate decision maker) or both.[7] In 1990, the federal Patient Self-Determination Act (PSDA) was enacted to promote the use of written advance directives.[8] Passage of the PSDA followed the United States Supreme Court June 25, 1990 decision in *Cruzan v. Director, Missouri Department of Health.*[9] Writing for a divided Court in a 5-4 opinion, Chief Justice Rehnquist determined, among other things, that the United States Constitution did not forbid Missouri from requiring that there be clear and convincing evidence of an incompetent patient's wishes relative to the withdrawal of life-sustaining treatment.[10]

The PSDA requires health care facilities receiving federal funds to inform patients of their rights under state law to prepare an advance directive, to inquire and document whether patients have executed a directive, to ensure compliance with state laws by respecting advance directives, and to educate health care providers regarding these legal instruments.[11] The same year the federal PSDA was enacted, New York amended its Public Health Law (PHL) to permit a patient with capacity to appoint a health care agent.[12] Codified at article 29-C of the PHL, the health care proxy statute was in derogation of the common law which, similar to the State of Missouri, did not permit a third person to make a decision to forgo life sustaining treatment on behalf of a patient lacking decision-making capacity in the absence of clear and convincing evidence of the patient's prior competent choice.[13] There is no legislation in New York expressly authorizing living wills, but they are recognized under the common law and health and mental health regulations[14] as evidence of the patient's intentions pertaining to the rendition or withholding of treatment. Moreover, New York's Family Health Care Decisions Act provides that there is no need to seek a surrogate decision about treatment, including life-sustaining treatment, if the patient already made the decision expressed in writing, which would include a living will.[15]

While legal scrutiny in New York has been afforded primarily to life sustaining treatment cases,[16] a legally authorized surrogate, such as a health care agent, is empowered to make any and all health care decisions on the principal's behalf that the principal could make.[17] This legal principle becomes particularly relevant when examining the use of psychiatric advance directives.[18] Courts have long recognized that all patients, including patients with severe mental illness, have the right to participate meaningfully in the course of their own treatment, to be free from unnecessary or unwanted medication, and to have their rights of personal autonomy and bodily integrity respected by agents of the state.[19]

A person is not deemed incapable of making medical decisions by simply virtue of a psychiatric diagnosis. Nonetheless, a mental illness may render a person temporarily unable to make informed choices regarding his or her care and treatment.[20] Psychiatric advance directives (PADs) were introduced as a means for people with psychiatric conditions to retain choice and control over their own mental health treatment during periods of decisional incapacity.[21] A PAD can be "instructive" enabling a person to specify treatment to be administered or refused when incapacitated, or take the form of a proxy directive permitting patients (principals) to appoint a representative to make health care decisions, or a combination of both.[22] Notably, the Center for Medicare and Medicaid Services (CMS) endorses the use of the PAD, recognizing that a PAD is akin to a traditional advance directive for health care. Further, CMS recommends that a PAD be accorded the same respect and consideration that a traditional advance directive for health care is given even where state law has not explicitly sanctioned their use.[23]

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II. A COMPARISON OF PAD STATUTES OF OTHER STATES AND THE NEW YORK HEALTH CARE PROXY LAW

Article 29-C of the Public Health Law makes no distinction between a health care agent's authority to make medical decisions and the authority to make mental health elections on behalf of a principal deemed to lack capacity. Health care for purposes of New York's statute is, in fact, defined as any treatment, service or procedure to diagnose or treat an individual's physical or mental condition.[24] In contrast, some states have specialized PAD statutes.[25] A PAD executed in another state or jurisdiction in compliance with the law of that state or jurisdiction shall be considered validly executed for purposes of New York law.[26] While New York is a general advance directive state, PAD forms are in use and available on line.[27] Research suggests that although 70% of patients with mental illness would want a PAD if offered assistance completing one, less than 10% have actually executed a PAD.[28] The literature is replete with analyses related both to the benefits and shortcomings of the PAD and confusion about the utility of PADs may be contributing to their underutilization in practice.[29]

Whether executed in an express PAD jurisdiction or in a general advance directive state such as New York, there are many benefits associated with PADs. These benefits include the potential to empower individuals with mental illness relative to their treatment choices, increase their satisfaction, motivation and treatment adherence, enhance continuity of care, promote early intervention and preventative care, encourage treatment collaboration and communication between the patient, family and clinical team, decrease reliance on coercive measures, assist in crisis de-escalation, and decrease hospitalization and the need for judicial intervention to compel treatment.[30]

Potential problems with PADs include insufficient education regarding the role of these instruments and the formalities associated with their execution as well as misunderstandings among clinical staff and providers regarding the utility of PADs. There are questions surrounding legality and liability, especially when a person elects to create a PAD to refuse treatment seen as critical in a crisis. There is also the potential for stigmatizing people with mental illness using distinct psychiatric advance directives (with their related rules and susceptibility to override by physicians) as somehow different from patients with cognitive impairments who complete general health care advance directives.[31] With respect to this latter pitfall, the potential for physician override of a PAD is perhaps the most controversial aspect of these advance planning tools.[32] In addition, there is little guidance on how laws governing mental health advance directives and civil commitment statutes are to be reconciled with one another.[33]

In states with PAD statutes, physician override of a PAD may be permitted under the following circumstances:

- where there is a court order finding incapacity;
- in case of emergency involving imminent threat of harm to the mental health service recipient or others; or where PAD instructions have not been effective in reducing the severity of the behavior causing the emergency; or, in an emergency where there is substantial risk of death or immediate and serious harm to the patient and within a reasonable degree of medical certainly the individual's health and safety would be affected adversely by delaying treatment;
- where there is a court order that contradicts the PAD instructions;
- where there is a court order authorizing involuntary commitment;
- where there is substantial evidence that failure to override would result in harm to the principal;
- if, in the opinion of the mental health professional, compliance with the PAD instructions is not consistent with generally accepted community standards of treatment, or the requested treatment is medically ineffective;
- if compliance is not consistent with court-ordered treatment.[34]

To date, the only reported decision interpreting a mental health advance directive statute in the commitment context is *Hargrave v. State of Vermont*.[35] In *Hargrave*, the Second Circuit Court of Appeals examined the validity of a Vermont statute that was alleged to violate the Americans with Disabilities Act (ADA). Pursuant to Vermont law, a civilly committed or imprisoned patient's previously executed durable power of attorney for psychiatric treatment preferences could be overridden through a petition by a health care professional to involuntarily medicate the patient. However, the procedure available to other incapacitated patients in Vermont allowed for a durable power of attorney for medical treatment preferences to be overridden in only two distinct circumstances; i.e., by the patient's revocation of the power of attorney or by a third party's petition to suspend the power of attorney in conjunction with the appointment of a guardian for the individual. According to the challenged statute, the committed patient's previously executed durable power of attorney would be honored for 45 days, during which the facility would observe any improvement to the patient's condition in the absence of the rejected medication. If no improvement appeared, the court would determine whether to forcibly administer the medication pursuant to the health care professional's petition. Plaintiff argued that the more relaxed override provisions pertaining to individuals with mental illness who were otherwise qualified to execute durable powers of attorney was discriminatory and violated the ADA.

The state-defendants in *Hargrave* invited the appeals court to hold that the initial judicial determination of dangerousness at the time of civil commitment was sufficient to exclude otherwise qualified mentally ill people from the protections of the ADA permitting the durable powers of attorney to be overridden. Specifically, the defendants maintained that the "direct threat" exception[36] of the ADA applied and that the exception continued for the entire length of the patient's commitment. The Second Circuit Court of Appeals ruled in favor of the plaintiff, however, concluding that the ADA's direct threat exclusion was inapplicable because Vermont failed to demonstrate that every civilly committed person subject to the statute's abrogation procedures posed a direct threat of harm to others sufficient to exclude her from the protections of the ADA.

The conclusion rested on two principles. First, the court observed that civil commitment in Vermont was based on a finding that the individual poses a danger to self or others, whereas the direct threat defense under the ADA requires the person to pose a risk of harm to *others*. Second, the court emphasized the significant delay in time between the initial civil commitment and abrogation of the durable power of attorney and the lack of an individualized hearing prior to the latter. By virtue of these findings, and others, the Second Circuit held that the Vermont statute impermissibly discriminated against qualified individuals who meet the essential eligibility requirements for maintaining durable power of attorneys and enjoined enforcement of the statute.

Given the decision in *Hargrave*, it appears that PAD-specific laws of other jurisdictions that permit a physician or court to override a person's prior capacitated choice are susceptible to challenge under the ADA. In contrast to Vermont, New York's health care proxy statute does not distinguish between medical and mental health treatment decisions and does not contain specific abrogation provisions. Absent conscience objections, a health care provider is obligated to comply with health care decisions made by an agent in good faith under a health care proxy to the same extent as if such decisions had been made by the principal.[37] Thus, the only limitations on the enforcement or revocation of advance mental health treatment directives in New York are potentially found in the state's civil commitment statutes,[38] under the common law[39] or under article 29-C itself which does not permit a health care proxy to be revoked by a principal determined by a court of law to be incompetent.[40] However, no reported decision in New York has squarely addressed these issues. The literature suggests that to survive scrutiny under the ADA, overriding PAD instructions can occur when the directive poses a direct threat to the health or safety of others or where there is a direct threat to the patient's life caused by a mental health emergency.[41] An individualized dangerousness assessment at the time of abrogation is also likely required to conform to the ADA.[42]

Also implicated in New York are statutory and regulatory strictures which must be satisfied before a health care proxy may be executed or revoked. In this regard, if a person executes a health care proxy while resident in a facility licensed or operated by the Office of Mental Health or the Office for People with Developmental Disabilities, witnesses to the proxy must have special clinical credentials.[43] The witnessing requirements are intended to ensure that the patient has capacity to execute the advance directive. Further, as provided for at section 2985 of the PHL, a competent adult may revoke a health care proxy 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. For purposes of the statute, every adult shall be presumed competent unless determined otherwise pursuant to court order. Of course, in New York, only in rare instances do plenary adjudications of incompetence survive and thus, even a person with a legal guardian retains all powers and rights except those powers and rights which the guardian is granted[44] and thus, may be able to revoke a health care proxy or execute a new one.[45]

"Our state statute further provides certain safeguards to protect an individual's ability to challenge an unwanted health care decision even if she has been deemed incapacitated, thus, in effect, circumventing the inability to revoke."

Our state statute further provides certain safeguards to protect an individual's ability to challenge an unwanted health care decision even if she has been deemed incapacitated, thus, in effect, circumventing the inability to revoke. Section 2983 of the PHL provides, for instance, that notwithstanding a determination pursuant to this section that the principal lacks capacity to make health care decisions, where a principal does object 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. Moreover, our state law permits the commencement of a special proceeding to resolve disputes arising under the law.[46] In the opinion of the authors, a principal's potential inability to revoke a health care proxy in the event of future incapacity should not dissuade the person from executing a PAD, nor outweigh the value of a PAD that expresses treatment wishes based upon past experiences and an understanding of treatment options. Furthermore, in a judicial proceeding, the treatment preferences articulated in a PAD would likely constitute clear and convincing

evidence of the individual's preferences and wishes, thus providing the court with a basis to determine whether a proposed treatment is appropriate for a person who has lost decisional capacity.

A concomitant issue is whether the mental health directives expressed in a PAD document could defeat a *Rivers* application commenced to override a patient's objection to the administration of psychiatric treatments.[47] It might be argued that if a *Rivers* application is commenced invoking the *paren patriae* powers of the state, a judicial override of PAD instructions can only occur upon an individualized finding of dangerousness to survive scrutiny under the ADA.[48] While a hospital cannot be prevented from commencing a *Rivers* proceeding, a PAD which contains articulated reasons for definitely expressed treatment preference may be instructive to fact finders. That is, the PAD may be used at both the administrative review preceding the *Rivers* application[49] and in court to aid the judge in narrowly tailoring any involuntary treatment order to give substantive effect to the patient's liberty interest.[50] At the very least, the PAD offers clear and convincing evidence of the patient's treatment preferences expressed at a time when the individual had the capacity to make treatment decisions that should be honored by the hospital and the court.

III. CONCLUSION

While New York does not have a specific mental health advance care directive statute, Article 29-C of the PHL provides for the appointment of a single health care agent empowered to make both medical and mental health care decisions. A principal is also permitted to include instructions regarding future care within her advance directive. Psychiatric advance directives are a valuable planning tool for people with mental illness. Their execution should be encouraged in order to afford individuals with mental disabilities the greatest autonomy possible in relation to their health care. There is uncertainty in the law as to whether and when a PAD may be overridden and the relationship between the PAD and civil commitment is ill-defined. Nonetheless, the potential for PADs to enhance the effectiveness of mental health treatment and avoid the need for involuntary care and treatment are laudable public health goals that should be pursued through education and outreach.

Endnotes

1 National Resource Center on Psychiatric Advance Directives: www.nrc-pad.org.

2 *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129 (Cardozo, J.).

3 *In re Storar*, 52 N.Y.2d 363; *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, *supra*).

4 *Rivers v Katz*, 67 N.Y. 2d 485, 492-493, *citing, Matter of Storar,* 52 N.Y. 2d 363, *supra, Matter of Harry M.*, 96 A.D.2d 201.

5 PHL 2504, 2805-d.

6 PHL 2983(5), 2994-c (6).

7 Jeffery W. Swanson, PhD, S. Van McCrary, PhD., Marvin S. Swartz, MD., Eric B. Elbogen, PhD., and Richard A. Van Dorn, PhD., *Superseding Psychiatric Advance Directives: Ethical and Legal Considerations,* 34 J. Am. Acad. Psychiatry Law 385, 386 (2006).

8 Codified at 42 U.S.C.A. 1395cc (f).

9 497 U.S. 269. The only other state with such a stringent rule was New York. *See Matter of Westchester County Med. Ctr. (O'Connor)*, 72 N.Y.2d 517.

10 The *Cruzan* majority also determined that state courts did not commit constitutional error in concluding that evidence adduced at trial did not amount to clear and convincing evidence of the patient's desire to cease hydration and nutrition; and finally, that due process did not require state to accept substituted judgment of close family members absent substantial proof that their views reflected those of patient. *See* 497 U.S. at 282-287.

11 42 U.S.C.A. 1395cc (f). Despite the enactment of the PSDA, research suggests that the prevalence of written medical advance directives in the general public remains no higher than 25 percent and did not substantially increase after passage of the federal law. *See* Swanson, *supra* note 7, p 387 and authorities cited therein.

12 L. 1990, c. 752. The legislation was based upon the consensus recommendations of the Task Force on Life and the Law convened by Governor Mario Cuomo in March 1985.

13 *In re Westchester County Med. Ctr. (O'Connor)*, 72 N.Y.2d 517, 530-531 *supra.* In *O'Connor*, the Court of Appeals stated: Every person has a right to life, and no one should be denied essential medical care unless the evidence clearly and convincingly shows that the patient intended to decline the treatment under some particular circumstances.

14 As stated in *O'Connor*, the ideal situation for evidence of a prior competent choice by a patient who now lacks decision making capacity is through a living will (72 N.Y.2d at 532). The existence of a writing suggests the author's seriousness of purpose and ensures that the court is not being asked to make a life-or-death decision based upon casual remarks. Further, a person who has troubled to set forth his or her wishes in a writing is more likely than one who has not to make sure that any subsequent changes of heart are adequately expressed, either in a new writing or through clear statements to relatives and friends. In contrast, a person whose expressions of intention were limited to oral statements may not as fully appreciate the need to rescind those statements after a change of heart (*id.*).

15 PHL § 2994-d.3(a)(ii).

16 *In re Storar*, 52 N.Y.2d 363, *supra; In re O'Connor,* 72 N.Y.2d 517 *supra.*

17 PHL 2982 (1).

18 *See* Judy Ann Clausen, *An Americans with Disabilities Act Critique of Advance Directive Override Provisions,* 71 N.Y.U. Ann. Surv. Am. L. 25, 26 (2015). General advance directives (generic directives) typically address end-of-life care, but mental health advance directives (mental health directives) govern treatment administered during periods of incapacity caused by acute mental illness episodes.

19 *See, e.g. Disability Rights New Jersey, Inc. v. Velez,* 974 F. Supp. 2d 705,709 (2013), *aff'd*, 796 F.3d 293 (3d Cir. 2015).

20 *Rivers v. Katz,* 67 N.Y.2d 485, *supra* note 4.

21 Swanson *et al.*, *supra* note 7.

22 *See* Patricia Backlar, *Anticipatory Planning for Psychiatric Treatment Is Not Quite the Same as Planning for End-of-Life Care*, 33 Community Mental Health J. 261 (1997): *see also,* Clausen, *supra* note 17 at 33-34.

23 CMS State Operations Manual, Appendix A—Survey Protocol, Regulations and Interpretative Guidelines for Hospitals, Interpretive Guideline A -0132 p. 94-95.

24 PHL 2980(4). State law further provides that mental hygiene facilities (and residential heath care facilities) shall establish procedures: (a) to provide information to adult residents about

their right to create a health care proxy; (b) to educate adult residents about the authority delegated under a health care proxy, what a proxy may include or omit, and how a proxy is created and revoked; (c) to help ensure that each resident who creates a proxy while residing at the facility does so voluntarily. *See* PHL 2991 (1).

25 National Resource Center on Psychiatric Advance Directives: www.nrc-pad.org; Clausen, *supra* note 17. The states with specialized PAD statutes are Arizona, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Montana, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Washington and Wyoming.

26 PHL 2990.

27 See, The Advance Directive Provider Training Project, New York Association of Psychiatric Rehabilitation Services, Planning for Your Mental and Physical Health Care and Treatment, http://www.nrc-pad.org - last visited March 19, 2017.

28 Eric Elbogen, Jeffrey Swanson, Paul Appelbaum, Marvin Swartz, Joelle Ferron, Richard Van Dorn, H. Ryan Wagnor, *Competence to Complete Psychiatric Advance Directives: Effects of Facilitated Decision Making*, 31(3) Law Hm. Bav. 275-289 (2007).

29 *See*, *e.g.*, Clausen, *supra,* note 17; Nat'l Ethics Comm. Veteran's Health Administration, *Advance Directives for Mental Health: An Ethical Analysis of State Laws & Implications for VHA Policy* (Feb. 2008), available on line at www.ethics.va.gov/docs/necrpts/NEC_Report_20080220_Adv_Directives_MH-Analysis of_State_Laws-Implications_for_VHA_Policy.pdf - last visited March 17, 2017.

30 Elbogen et al., *supra* note 27; *see also* U. Penn Collaborative on Community Integration, Psychiatric Advance Directives: Pros, Cons, and Next Steps. tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/self_determination_psychiatric_advanced_directives_self_directed_care/Psychiatric_Advance_Directives.pdf, last visited March 17, 2017.

31 *Id.*

32 Swanson et al., *supra* note 7; Paul Appelbaum, *Commentary: Psychiatric Advance Directives at a Crossroads-When Can PADs Be Overridden*, 34 J. Am. Acad. Psychiatry Law 395 (2006).

33 Clausen, *supra* note 17, p. 35. There is no national consensus concerning the interaction of commitment statutes and mental health directives which is one reason why the Uniform Law Commission refrained from enacting a model mental health directive statute. *Id.* at p.37.

34 Clausen, *supra* note 17, p 50-61. In contrast, across jurisdictions, overriding a generic advance directive may occur when the patient's treatment preferences are (1) outside the standard of care; (2) unavailable; (3) medically ineffective; or illegal. *Id* at 49. *See* Uniform Health Care Decisions Act 7(e). 9 U.L.A. 27-28 (2010).

35 340 F.3d 27 (2d Cir. 2003).

36 The ADA does not require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services. 42 U.S.C. 12182(b)(3).

37 PHL 2984 (2-4).

38 *See* MHL 9.27, 9.33, 9.37, 9.39.

39 *Rivers v. Katz*, *supra* note 4, 67 N.Y. 2d 485.

40 PHL 2985 (1)(b).

41 Clausen, *supra* note 17, p 75-78.

42 Clausen, *supra* note 17, p 77.

43 PHL 2981 (1)(b)(c): *see also*, 22 NYCRR 22.3 - When a Patient May Sign Legal Instrument.

44 MHL 81.29 (a).

45 Robert Swidler, *Health Care Proxies—Ten Difficult Issues*, 88 N.Y.St. B.J. 28 (July/August 2016).

46 PHL 2992.

47 *Rivers v. Katz*, *supra* note 4, 67 N.Y. 2d 485.

48 Clausen, *supra* note 17, p 77.

49 *See* 14 N.Y.C.R.R. part 527.

50 *Rivers v. Katz*, *supra* note 4, 67 N.Y. 2d at 497–98.