APPLYING FAMILY MEDIATION TO THE CREATION OF PSYCHIATRIC ADVANCE DIRECTIVES

*Olivia Kalsner Kershen**

I. Introduction

Since she was 13 years old, Ariel Wolf has been hospitalized for psychiatric treatment over 30 times.[1] She suffers from bipolar disorder with psychotic features and experienced incidents throughout her teenage years in which she inflicted self-harm over 5,000 times.[2] Now, at twenty-five years old and working as a mental health peer support specialist, Ariel is aware of what treatments work for her and what actions must take place in the event she experiences a crisis.[3] She is able to instruct her providers on her choices, even in the event she cannot communicate her wishes to the fullest extent. This is because Ariel completed a legal document called a Psychiatric Advance Directive ("PAD") when she turned eighteen.[4]

PADs are relatively new legal documents that allow people to specify preferences for future mental health treatment, including the appointment of healthcare proxies to interpret their requests in the event of a crisis.[5] They are modeled after traditional forms of advance medical directives typically used to express decisions for end-of-life healthcare (e.g. when to use life-sustaining interventions).[6] PADs are

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1 Pam Belluck, *Now Mental Health Patients Can Specify Their Care Before Hallucinations and Voices Overwhelm Them*, N.Y. Times (Dec. 3, 2018), https://www.nytimes.com/2018/12/03/health/psychiatric-advanced-directives.html?auth=forgot-password&referring_pv_id=kTCPn80vc6ffc-lQ4QSWE_hx [https://perma.cc/E5MB-KLGG].

2 *Id.*

3 *Id.*

4 *Id.*

5 *State by State Info*, Nat'l Rsch. Ctr. Psychiatric Advance Directives, https://nrc-pad.org/states/ [perma.cc/SL25-PNHP] (last visited Feb. 12, 2023) [hereinafter *States*].

6 Jeffrey W. Swanson, et al., *Psychiatric Advance Directives: A Survey of Persons with Schizophrenia, Family Members, and Treatment Providers*, 2 Int'l J. Forensic Mental Health 73, 73 (2003).

used to plan for specific events when a person may lose the capacity to give or withhold informed consent for psychiatric treatment.[7] A PAD can be created when an individual has the ability to consider their options for treatment and comes into use in the event of a mental health emergency.[8]

Ariel Wolf's PAD states that she objects to the use of electroconvulsive therapy and antipsychotic medications.[9] Her PAD also instructs that her parents be contacted in the event of hospitalization.[10] It also gives permission for them to communicate with her medical providers about her treatment preferences, which she credits as a crucial aspect of her care.[11] For some people like Ariel living with serious mental health diagnoses, family involvement can be central to their recovery.[12] At the same time, it can be a challenge to balance a family's concern for a person's treatment with an individual's right to autonomy in medical decision-making. For millions of Americans living with serious mental illnesses like Ariel,[13] there can be decades-long struggles involving hospitalizations, outpatient treatment centers, and even courts. For family members of loved ones living with these illnesses, it can feel as though they are unable to adequately help due to strong federal safeguards surrounding individual rights to privacy.[14] While these laws and regulations are central to individual civil rights, they can limit the ability of family members who are familiar with a patient's needs to contribute to their care if they are not a legally designated proxy.

This Note proposes that for individuals in the process of creating a PAD, who have close family ties and seek their family's involvement, mediation can be used where the individual values the opinions of their family members regarding their mental health treatment. The goal of applying mediation to these situations is to help individuals have productive conversations with their families about their intentions for future care. The mediation process can also serve to address concerns between the parties surrounding any potential disagreements. Applying mediation to PAD formation

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7 *States*, *supra* note 5.

8 *Id.*

9 Belluck, *supra* note 1.

10 *Id.*

11 *Id.*

12 Francesca Pernice-Duca, *Family Network Support and Mental Health Recovery*, 36 J. Marital & Fam. Therapy 13, 23 (2010).

13 *See Mental Illness Statistics*, Nat'l Inst. Mental Health, https://www.nimh.nih.gov/health/statistics/mental-illness [https://perma.cc/G2Q7-A9ZM] (last visited Feb. 12, 2023) ("In 2020, there were an estimated 14.2 million adults aged 18 or older in the United States with SMI.").

14 45 C.F.R. § 164.502(g).

could help to potentially reduce strenuous emotional conflict that leads to uncomfortable disputes, strengthen family bonds, and allow for open discussion of future treatment in a productive manner that centers the needs and autonomy of the principal PAD writer. These are important factors to consider because of the central importance that family support has for some individuals living with serious mental illnesses.[15]

First, the Background section of this Note will provide context for how mental healthcare practices have evolved over the course of American history. It will outline the changes in hospitalization procedures in the United States and examine current involuntary commitment standards. The purpose of this is to inform the reader of how ideologies surrounding psychiatric treatment have shifted over time and gave way to patient-centered concepts like psychiatric advance directives. This Note will then establish an understanding of how advance directives have come into common use over the past several decades for healthcare decision-making. The Discussion section will move into an overview of PADs: how they are formed, the benefits they have for patients, as well as their shortcomings. Part III(B) will analyze the implications of family involvement for a PAD writer's mental healthcare, which gives context as to why family discussions play a crucial role in PAD formation. Finally, the Proposal section of this Note will put forward an idea for integrating mediation as a component of PAD formation, along with its incentives and limitations.

II. Background

This section will begin by providing a brief overview of the development of treatment ideologies in mental healthcare in the United States. A historical overview will provide context for the ways in which ideals of mental health treatment and concepts of patient autonomy have changed over the course of American history. The next section will look at the current standards for involuntary treatments, such as forced medication and involuntary hospitalizations, which are the situations where PADs would come into use. Finally, this section will look at the history of advance directives. This history will give an understanding of the case law and legislation that led to the widespread implementation of advance directives for medical decision-making before they were applied in the mental healthcare context through PADs.

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[15] Pernice-Duca, *supra* note 12, at 23.

A. *History of Involuntary Treatment in the United States*

Over the past two centuries, the landscape of mental healthcare in the United States has evolved dramatically. In the mid-nineteenth century, state-run asylums were the model of care for Americans with disabilities and severe mental illnesses.[16] This system of treatment was promoted by activists of the time like Dorothea Dix.[17] Dix was an outspoken advocate and played a vital role in the reform of mental health treatment in America during the 1800s.[18] She fought to improve standards of care for Americans living with mental illnesses after witnessing many living in jails and almshouses in deplorable conditions.[19] She led a movement "that challenged the idea that people with mental disturbances could not be cured or helped."[20] One of the first facilities to open under Dix's conceptualization of mental illness was the Worcester State Hospital in Massachusetts in 1833.[21] The hospital founders sought to emulate a practice known as "moral treatment."[22] This method of treatment placed great importance on locating patients in a pastoral setting because its goal was to help patients become "quiet, peaceable, intelligent, and reasonable."[23] When being admitted to hospitals like Worcester State, "[t]ypically, a family member would propose admission, and a physician would certify the admission for an indefinite period."[24] The individuals living with serious mental illness had little to no say in the course of their treatment.[25] Physicians and the greater public simply "presumed that all mentally ill patients had compromised reason . . . that they were unable to request (or refuse) care on their own behalf."[26]

After several decades of operation, public opinion on large state-run hospitals dramatically worsened. This was motivated in part by

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16 Gerald N. Grob, *Mental Health Policy in America: Myths and Realities*, 11 Health Aff. 7, 8 (1992).

17 Substance Abuse & Mental Health Services Admin. Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice 3 (2019) [hereinafter *Care Continuum*].

18 Manon S. Parry, *Dorothea Dix (1802-1887)*, 96 Am. J. Pub. Health 624, 624 (2006).

19 *Care Continuum*, *supra* note 17.

20 Parry, *supra* note 18.

21 *Care Continuum*, *supra* note 17; *see also* Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment—The American Experience*, 43.3 Isr. J. Psychiatry & Related Scis. 209, 210 (2006).

22 *The First Worcester State Hospital*, Worcester Hist. Museum Libr. & Archives, https://worcesterhistorical.com/worcester-state-hospital/the-first-worcester-state-hospital/ [https://perma.cc/9EGU-LPL9] (last visited Feb. 12, 2023).

23 *Id.*

24 *Care Continuum*, *supra* note 17.

25 Anfang & Appelbaum, *supra* note 21, at 210.

26 *Id.*

publicized accounts from journalists and mental health professionals of the neglected state many facilities were operating in during the first half of the twentieth century.[27] One notable example came in 1908 from *A Mind that Found Itself*, an autobiography written by Clifford Whittingham Beers based on his personal experiences being institutionalized.[28] In the book, Beers recounted: "I was continuously either under lock and key (in the padded cell or some other room) or under the eye of an attendant. Over half the time I was in the snug, but cruel embrace of a strait-jacket—about 3 hundred hours in all."[29] Similarly grim portrayals were later highlighted in the well-known exposés, *The Shame of the States* by Albert Deutsch, and *Bedlam 1946* by Albert Q. Maisel.[30] These portrayals aided a shift in the public opinion of Americans and their desired approach to treating the mental health of its citizens.[31]

In 1946, Congress passed the National Mental Health Act, which was intended to address public concerns regarding the mental health of veterans returning from World War II.[32] The Act provided funding for expanded psychological research, professional training, and grants for states to establish mental health centers.[33] The bill also called for the establishment of the National Institute of Mental Health ("NIMH"), which was formed in 1949.[34] In 1952, the Draft Act Governing Hospitalization of the Mentally Ill was released by the NIMH as a model to help states create regulation that placed the process of hospital admissions in greater control of medical professionals, and upheld voluntary treatment as a goal when admitting people to inpatient hospitalization.[35] However, this placed a massive amount of discretion in the hands of physicians who could choose through their sole discretion to institutionalize someone

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[27] Grob, *supra* note 16, at 13; *see also* Blake Erickson, *Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963*, 16 Am. J. Psychiatry Residents' J. 6, 6 (2021).

[28] José M. Bertolote, *The Roots of the Concept of Mental Health*, 7 World Psychiatry 113, 113 (2008).

[29] Clifford Whittingham Beers, A Mind That Found Itself: An Autobiography 136 (Longmans, Green, and Co., 1908), *as reprinted in Voices from the Past*, 100 Am. J. Pub. Health 2354, 2354 (2010).

[30] Erickson, *supra* note 27, at 6; *see also* Albert Q. Maisel, *Bedlam 1946: Most U.S. Mental Hospitals are a Shame and a Disgrace*, PBS, https://www.pbs.org/wgbh/americanexperience/features/lobotomist-bedlam-1946/ [https://perma.cc/7VNS-UCVX] (last visited Feb. 12, 2023).

[31] Grob, *supra* note 16, at 13.

[32] Ellen Herman, The Romance of American Psychology: Political Culture in the Age of Experts 245 (Berkely & Univ. of Cal.: L.A. Press, ed.,1995).

[33] *Id.* at 247.

[34] *Id.*; *Important Events in NIMH History*, Nat'l Insts. Health, https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh#events [https://perma.cc/V64Z-ENGB] (last visited Feb. 12, 2023).

[35] Paul S. Appelbaum, *The Draft Act Governing Hospitalization of the Mentally Ill: Its Genesis and Its Legacy*, 51 Psychiatric Serv. 190, 190 (2000).

if they deemed them in need of treatment and lacking capacity or insight to their condition. During the 1950s and 60s, a larger push was made to transition mental healthcare out of hospitals as civil rights advocates and social activists highlighted that the institutional practices stripped patients of constitutional liberties.[36] Coupled with the advent of several effective psychiatric medications, this movement led President John F. Kennedy to sign into law the Community Mental Health Centers Act of 1963.[37] The Act allocated $150 million for states to construct 1,500 community mental health centers that would provide five essential services: consultation and education for community organizations, inpatient facilities, outpatient clinics, emergency response, and partial hospitalization.[38]

Along with shifting the majority of treatment to outpatient care, states began to adopt heightened standards for civil commitment and involuntary treatment. In 1966, the Court of Appeals for the District of Columbia held in *Lake v. Cameron* that involuntary mental health treatments "should not go beyond what is necessary for [the patient's] protection."[39] The criteria for involuntary commitment then narrowed from the previous "need for treatment" standard to now require that patients must pose a danger to themselves or others in order to be subject to involuntary commitment.[40] This was largely adopted through the Supreme Court's holding in *O'Connor v. Donaldson* in 1975, which stated that "a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[41] Four years later in *Addington v. Texas*,[42] the Supreme Court established a burden of proof requiring that civil commitment proceedings must be held to a "clear and convincing" evidence standard, in recognition that "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."[43] This standard falls in between the higher reasonable-doubt standard required in criminal

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36 Grob, *supra* note 16, at 16.

37 Erickson, *supra* note 27, at 6.

38 *Id.* at 7; *see generally Mental Health Care (partial hospitalization)*, MEDICARE, https://www.medicare.gov/coverage/mental-health-care-partial-hospitalization [https://perma.cc/8E2U-PMDR] (last visited May 20, 2023) (defining partial hospitalization as a structured outpatient psychiatric treatment program that is an alternative to inpatient treatment).

39 Lake v. Cameron, 364 F.2d 657, 660 (D.C. Cir. 1966).

40 Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 PSYCHIATRY (EDGEMONT) 30, 33 (2010).

41 WestLaw Synopsis, J.B. O'Connor v. Kenneth Donaldson, 422 U.S. 563 (1975); *see also* Testa & West, *supra* note 40, at 33–34.

42 *See* Testa & West, *supra* note 40, at 34.

43 Frank O'Neal Addington v. State of Texas, 441 U.S. 418, 425 (1979).

cases, and the lower-level preponderance-of-the-evidence standard of most civil lawsuits.

In sum, the purpose of the historical overview provided in this subsection is to give greater context regarding the United States' evolving conceptualizations of mental health. This is in order to demonstrate the ways in which societal interests in patient rights have shifted over time so that individuals are now able to instruct and inform physicians about their preferences for care.

B. *Current Standards for Involuntary Treatment*

This subsection will explore how the standards for determining civil commitment have broadened since the 1970s and provide an overview of some states' approaches to involuntary psychiatric treatment.[44] While many states still maintain a dangerousness standard for commitment, the qualifications for dangerousness have expanded.[45] Part of the reasoning for this is that 'propensity for violence' is a complex behavior determined by multiple factors.[46] In general, the way the law addresses dangerousness requires an assumption that any violent tendencies are due to a person's mental illness, and that treatment would help to alleviate this symptom.[47] This allows less room for nuance regarding the indeterminate causes of erratic or violent behavior. Additionally, upholding a standard based purely on dangerousness neglects individuals who could potentially benefit from intervention as it requires that the person must further deteriorate to an extreme level in order to meet a commitment standard.[48] Because of this, many states have created alternative standards for commitment.[49] For example, in North Carolina, 'danger to self' can be a finding that a person is "unable, without care, supervision . . . to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety[.]"[50] In Oregon, a person can qualify for commitment if they are found to be dangerous, gravely disabled, or reasonably probable

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44 *Care Continuum*, *supra* note 17, at 8.

45 *Id.* ("Although dangerousness continues to serve as a commitment criterion in nearly every state, what must be shown to establish dangerousness has changed. In many states the risks presented no longer need be imminent or immediate.").

46 *Id.* at 9.

47 *Id.*

48 *Id.*

49 *Id.*

50 *Care Continuum*, *supra* note 17, at 10 (quoting N.C. Gen. Stat., § 122C-3(11)(a).

to deteriorate to a point where they will be deemed dangerous or gravely disabled.[51] As a result of statutes like these, there is not a bright line for defining dangerousness.[52]

In New York, the law provides a range of standards to qualify an individual for admission or involuntary psychiatric treatment. At the lowest level, a person can voluntarily admit themselves for care, which involves the patient making an application for treatment followed by an evaluation with hospital staff to ensure they meet admission criteria.[53] The next level above this is an informal admission, where the patient makes an oral request for treatment and is found not to pose a substantial threat of harm to themselves or others.[54] In order for a patient to be held for involuntary treatment under § 9.27 of the state's Mental Hygiene Law, it is required that the person's "judgment is too impaired for him/her to understand the need for such care and treatment" and that "as a result of his/her mental illness, the person poses a substantial threat of harm to self or others."[55] This finding requires a certification by two examining physicians[56] and a member of the hospital's psychiatric staff,[57] and allows for a person to be held up to sixty days before court authorization is necessary.[58] The most urgent form of commitment is regulated under the emergency standard, which applies when there is "a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide" or if the person has manifested homicidal or other violent behavior towards others.[59] Emergency commitment permits immediate admission without the need for an application and only requires the evaluation of one physician to find a person meets the criteria required for this acute treatment.[60]

Some states have also established intensive outpatient programs for individuals with chronic, severe mental illnesses. For example, in New York there is court-ordered Assisted Outpatient Treatment ("AOT") that was created through the statutory framework of Kendra's Law.[61] Kendra's law was enacted in 1999

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[51] *Id.*

[52] *Id.*

[53] NY Mental Hygiene Law § 9.13.

[54] NY Mental Hygiene Law § 9.15.

[55] NY Mental Hygiene Law § 9.27.

[56] NY Mental Hygiene Law § 9.27(a).

[57] NY Mental Hygiene Law § 9.27(e).

[58] NY Mental Hygiene Law § 9.33.

[59] NY Mental Hygiene Law § 9.39(a).

[60] NY Mental Hygiene Law § 9.39.

[61] *Assisted Outpatient Treatment*, N.Y. ST. OFF. MENTAL HEALTH, https://my.omh.ny.gov/analytics/saw.dll?dashboard&PortalPath=%2Fshared%2FAOTLP%2F_portal%2FAssisted%20Outpatient%20Treatment%20Reports&nquser=BI_Guest&nqpassword=Public123 [https://perma.cc/9664-3RRE] (last visited Feb. 12, 2023).

in response to the death of Kendra Webdale, a young woman who died after being pushed in front of a New York City subway by a man with an untreated serious mental illness.[62] The law was created to ensure that people with histories of psychiatric hospitalization or violence are connected to adequate mental healthcare through the AOT program.[63] Legislation similar to Kendra's Law has been implemented in several states in response to high-profile homicides perpetrated by people who had inadequately treated psychiatric illnesses.[64] This form of treatment has faced criticism for its coercive practices, but has also shown to reduce the likelihood of a more restrictive inpatient commitment.[65]

A challenge that continues to play out in the legislative and judicial regulation of involuntary treatment is the tenuous balance between the goal of the law to assert state police power and *parens patriae*, the goals of the medical profession that seek to "do no harm,"[66] as well as a third consideration: the requirement to uphold individual civil rights. Today, experts in mental health and civil rights fields largely oppose the use of involuntary treatment outside of true emergencies. The most recent public challenge to its use came in November 2022 after New York City Mayor Eric Adams put forward a directive that called on police to involuntarily commit people they observe in public if "it appears they cannot 'meet their basic needs.'"[67] Many organizations have spoken out against this directive as it will cause for increased policing of unhoused individuals, thereby heightening the risk of police violence against an already vulnerable population.[68] Meanwhile, controversial proponents like prominent psychiatrist Dr. E. Fuller Torrey advocate that compelled involuntary hospitalization in these cases is necessary to prevent potential acts of violence by those with untreated mental illness.[69]

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62 *Id.*

63 *Id.*

64 *Care Continuum, supra* note 17, at 2–4.

65 *Id.* at 19.

66 *See* Christyne E. Ferris, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards*, 61 Vand. L. Rev. 959, 966 (2008).

67 Patrick Fowler, *Organizations, Individuals from Across the Country Oppose Mayor Eric Adams' Plan to Increase Involuntary Commitment of New Yorkers with Mental Disabilities*, Nat'l Ctr. L. & Econ. Just. (Dec. 12, 2022), https://nclej.org/civil-rights-highlights/organizations-individuals-from-across-the-country-oppose-mayor-eric-adams-plan-to-increase-involuntary-commitment-of-new-yorkers-with-mental-disabilities [https://perma.cc/8AAY-LTUP].

68 *Id.*

69 Ellen Barry, *Behind New York City's Shift on Mental Health, a Solitary Quest*, N.Y. Times (Dec. 11, 2022), https://www.nytimes.com/2022/12/11/health/fuller-torrey-psychosis-commitment.html [https://perma.cc/Z7VW-QDLQ].

C. *History of the Advance Directive*

Advance directives were created as a combination of living wills with existing power of attorney laws and have primarily been used in end-of-life care.[70] The invention of the living will is primarily credited to Luis Kutner, a Chicago human rights lawyer.[71] Kutner first brought up the idea for a living will in late 1967 to members of the Euthanasia Society.[72] However, it was not until 1969 that his article, "Due Process of Euthanasia: The Living Will, A Proposal" was published.[73] In the article, Kutner proposed that similar to consent for treatment while one has capacity, an individual could outline specific intentions for treatment in the event they enter a state where they lose the ability to independently provide informed consent.[74] He compared the living will to a form of "revocable or conditional trust with the patient's body as the *res*, the patient as the beneficiary and grantor, and the doctor and hospital as trustees."[75] During the 1970s, interest in living wills grew dramatically, in part due to the major advancements made in medical technologies.[76] With the widespread implementation of the new life-sustaining interventions "it often became difficult to distinguish saving life from prolonging suffering and death . . . ."[77] The case of *In re Quinlan* helped to heighten public demand for living wills,[78] and by the mid-1980s, over forty states had adopted legislation regulating living wills.[79]

Separate from living wills, the concept of granting power of attorney had existed under the common law for many years, however these rights were traditionally revoked if the principal became

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70 Charles P. Sabatino, *The Evolution of Health Care Advance Planning Law and Policy*, 88 Milbank Q. 211, 216 (2010).

71 *Id.* at 212.

72 Udo Benzenhöfer & Gisela Hack-Molitor, *Luis Kutner and the Development of the Advance Directive (Living Will)* GWAB-Verlag (2009), https://d-nb.info/1095663763/34 [https://perma.cc/43HV-N8BY].

73 *Id.* at 26.

74 Luis Kutner, *Due Process of Euthanasia: The Living Will, a Proposal*, 44 Ind. L. J. 539, 550–51 (1969).

75 *Id.* at 552.

76 Sabatino, *supra* note 70, at 213.

77 *Id.*

78 Elizabeth M. Gallagher, *Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals*, 4 Psych. Pub. Pol'y & L. 746, 746 (1998); *see In re Quinlan*, 355 A.2d 647 (N.J. 1976) (a New Jersey Supreme Court case in which a father sought guardianship in order to discontinue life support for his 21-year-old daughter who was in a persistent vegetative state. The court held that in situations where a patient is unlikely to emerge from a comatose state, life-support can be withdrawn upon a physician's concurrence with the guardian and the family and their consultation with a hospital's ethics committee).

79 Sabatino, *supra* note 70, at 214.

incapacitated.[80] Additionally, the authority given through the power of attorney designation primarily focused on granting permission for the management of one's property.[81] In the 1950s, durable power of attorney statutes began to be enacted, but their application to healthcare did not occur until around the 1980s through durable powers of attorney for healthcare decision-making statutes.[82] The ability to designate a durable power of attorney allowed patients to assign a specific person to make medical decisions for them in the event they became incapacitated. During the 1990s, attention heightened even further around the concept of advance medical planning due to the Supreme Court's ruling in *Cruzan v. Director, Missouri Dept. of Health*. The *Cruzan* Court held that states were not required to follow substituted judgment expressed by family members regarding life-sustaining treatments for their loved ones absent "clear and convincing evidence" of that person's wishes.[83]

Furthermore, these events helped lead to the creation of the advance directive: a combination of the two separate, existing concepts of living wills and durable powers of attorney. The first federal regulation for advance directives came through the Patient Self-Determination Act in 1990, however, this legislation did not substantively establish nor modify any existing right to healthcare decision-making.[84] Its primary goal was to encourage Americans to place more thought and planning into healthcare decisions.[85] Under this law, facilities receiving Medicare or Medicaid reimbursements were now required to inform patients about their decision-making rights, which included options for advance directive creation.[86] Providers had to give all adult patients written information about their rights under the respective state law, document whether the person has an advance directive, educate staff about advance directives, and ensure compliance with state laws concerning advance directives.[87] The first state-level, holistic advance directive law was passed in New Jersey in 1991.[88] New Jersey codified this by combining living will regulation with power of attorney laws into what they called an "advance directive for health care."[89] The Act defines that an

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80 *Id.*

81 *Id.*; *see also* Catherine Seal, *Power of Attorney: Convenient Contract or Dangerous Document?*, 11 Marq. Elder's Advisor 307, 309 (2010).

82 Sabatino, *supra* note 70, at 214.

83 Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 292 (1990).

84 Sabatino, *supra* note 70, at 217.

85 *Id.*

86 U.S. Gov't Accountability Off., GAO/HEHS-95-135, Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain (1995).

87 *Id.*

88 Sabatino, *supra* note 70, at 216 (citation omitted).

89 *Id.* (citing NJ Stat. Ann § 26:2H-53 to -81).

advance directive can include a proxy directive, an instructional directive (living will) or both.[90] "In 1993, the National Conference of Commissioners on Uniform State Laws drafted the Uniform Health Care Decisions Act" to provide states with a model of the components necessary for creating advance directive legislation.[91] The Act was constructed to promote six essential concepts: (i) to acknowledge the rights of a competent person to decide all aspects of their health care in all circumstances; (ii) to provide jurisdictions with a comprehensive, singular statutory scheme; (iii) to simplify the process of creating and implementing advance health-care directives; (iv) to ensure that all decisions about a patient's care are governed by the individual's own desires; (v) to ensure compliance by health care providers and; (vi) to provide a procedure to resolve disputes that may arise surrounding health care decisions.[92] By 2002, all fifty states and the District of Columbia had at least one statute-based advance medical planning document for their residents, which could include a living will, durable power of attorney for healthcare, or both.[93] At that time, only sixty-three percent of states had state documents for both living wills and durable powers of attorney,[94] and there was still substantial variability regarding the content of these documents.[95]

III. Discussion

The first half of this section will provide an overview of what psychiatric advance directives are, and their origins. It will discuss when the documents first came into use, how they are drafted, the benefits they have for people living with serious mental illness, as well as their potential shortcomings when put in practice. The second half of this section will then discuss family involvement in mental health treatment processes. It will begin by explaining the positive implications that family involvement has for recovery outcomes. In the second half, it will look into their limitations and the negative consequences that some people experience from family participation in their mental health treatment.

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90 N.J. Rev. Stat. 26:2H-55 (2013).

91 Gail Gunter-Hunt, Jane E. Mahoney, & Carol E. Sieger, *A Comparison of State Advance Directive Documents*, 42 Gerontologist 51, 51 (2002).

92 Uniform Health Care Decisions Act, Nat'l Conf. Comm'rs Unif. State Ls. (1993).

93 Gunter-Hunt, Mahoney, & Singer, *supra* note 91, at 52.

94 *Id.* at 53.

95 *Id.*

A. *Overview of the Psychiatric Advance Directive ("PAD")*

"Psychiatric advance directives ("PADs") were [first] introduced in the 1980's . . . ."[96] In 2006, the Center for Medicare and Medicaid Services ("CMS") established regulations for psychiatric hospitals and health facilities, requiring that they provide information about PADs to patients and inquire about whether they have one.[97] For the most part, PADs were developed simultaneously with advance medical directives.[98] However, they differ largely due to their specific subject matter and the nuanced approach to treatment required for psychiatric care. Unlike living wills and advance medical directives, which "require thinking forward to a future state that a person has never experienced before[,]"[99] PADs are based off past experiences.[100]

1. Formation

While each state has varying procedures (some states involving specific PAD statutes, and some utilizing medical advanced directive laws) instructing the creation and implementation of psychiatric advance directives,[101] they tend to follow a similar general format. At the outset, a PAD form may require that the individual states their intent to create the advance directive.[102] Within the PAD, an almost universal component is the designation of another person as a healthcare proxy, or durable power of attorney to make treatment decisions in the event the writer is found "to be legally incompetent to make choices."[103] The PAD can include specific preferences regarding hospitalization, medication, and other forms of emergency interventions such as restraint or seclusion.[104] There may also be instructions for notifying other people in the event of an emergency

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96 Jeffrey W. Swanson et al., *Superseding Psychiatric Advance Directives: Ethical and Legal Considerations*, 34 J. Am. Acad. Psychiatry L. 385, 385 (2006).

97 Substance Abuse & Mental Health Serv. Admin., A Practical Guide to Psychiatric Advance Directives 8 (2019).

98 *Id.* at 7.

99 *Id.*

100 *Id.* at 6.

101 *See States*, *supra* note 5.

102 *See, e.g., Psychiatric Advance Directive Form*, Sanford Health, https://www.sanfordhealth.org/-/media/org/files/medical-services/behavioral-health/psychatric-advance-directive-form.pdf [https://perma.cc/PB7P-LXWN] (last visited Feb. 21, 2024); *see also Mental Health Advance Directive*, Wash. St. Health Care Auth., https://www.hca.wa.gov/assets/free-or-low-cost/mental-health-advance-directive-form.doc [https://perma.cc/AV4G-LDQC] (last visited Jan. 13, 2023).

103 *Advance Directives for Behavioral Health*, Substance Abuse & Mental Health Serv. Admin., https://www.samhsa.gov/section-223/governance-oversight/directives-behavioral-health [https://perma.cc/X5K2-VWWL] (last visited Nov. 18, 2022).

104 *Id.*

hospitalization, and temporary custody arrangements for children and pets.[105] Finally, the advance directive must be signed by two witnesses and witnessed by a notary.[106] Only around half of states currently have statutes that specifically govern PADs.[107] However, nearly all states have a form of advance directive law that can be used to apply to psychiatric treatment.[108]

New York, for example, does not have a formal statute for psychiatric advance directives.[109] Instead, the way the law is set out primarily concerns the appointment of a surrogate decision-maker in the event a patient is deemed incapacitated through its Healthcare Agents and Proxies law.[110] In the event a person has not designated a proxy, the Family Health Care Decisions Act, passed in 2010, outlines the regulations surrounding surrogate designations and the requirements necessary for determining "capacity." [111] While the legislation can be read broadly to include decision-making for mental healthcare, the Act reads as primarily addressing end-of-life care issues.[112]

Comparatively, in Illinois, there is specific legislation for the creation and use of psychiatric advance directive documents, but it is not dramatically different in function from the standards in New York. Illinois's Mental Health Treatment Preference Declaration Act lays out the rules and definitions that guide the creation of PADs and provides a form for the individual to fill out with their treatment preferences.[113] It requires that a person be of "sound mind" at the time of their PAD's formation.[114] In order to take effect, the declaration requires signatures from two "competent adult witnesses" [115] along with the individual, and then submission to the patient's attending physician.[116] The form is four pages long and asks for the person filling it out to list their preferences regarding psychotropic medications, electroconvulsive treatment, physicians, and inpatient admission.[117]

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105 *Id.*

106 *Id.*

107 *Getting Started*, Nat'l Res. Ctr. Psychiatric Advance Directives, https://nrc-pad.org/getting-started/ [https://perma.cc/H3EW-4NCE] (last visited Nov. 18, 2022).

108 *Id*.

109 *New York Forms*, Nat'l Res. Ctr. Psychiatric Advance Directives, https://nrc-pad.org/states/new-york-forms/ [https://perma.cc/VZ6S-RS8R] (last visited Feb. 11, 2023).

110 *New York Q and A*, Nat'l Res. Ctr. Psychiatric Advance Directives, https://nrc-pad.org/states/new-york-faq/ [https://perma.cc/S95S-FBHU] (last visited Feb. 11, 2023).

111 N.Y. Pub. Health L. § 2994-c.

112 N.Y. Pub. Health L. § 2994-b.

113 755 Ill. Comp. Stat. Ann. 43.

114 755 Ill. Comp. Stat. Ann. 43/10.

115 755 Ill. Comp. Stat. Ann. 43/20.

116 755 Ill. Comp. Stat. Ann. 43/25.

117 *Declaration for Mental Health Treatment*, Ill. Dep't Hum. Serv., https://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-2102.pdf [https://perma.cc/QN2R-P7XZ] (last visited Feb. 12, 2023).

It also gives space to designate an "attorney-in-fact:" a person appointed to make medical decisions should the patient become incapable.[118] The attorney-in-fact must accept their appointment to the role, and they cannot be a medical provider for the individual forming the declaration.[119] The attorney-in-fact is obligated to "act consistently with the desires of the principal as expressed in the declaration."[120] Once completed, the declaration is only valid for three years but can be revoked prior to then as long as the person is not "incapable."[121]

One of the most recent legislative advances was in Georgia, where new legislation specifically for psychiatric advance care planning was signed into law in 2022. The Georgia Psychiatric Advance Directive Act has many provisions similar to those of the Illinois law, however, it allows for a directive to stay in effect until revoked by the declarant.[122] These new statutory developments suggest that PAD awareness and use may continue to grow with time.

2. Benefits of PADs

The major benefit that PADs have brought to mental healthcare consumers is the ability to enhance autonomy and prevent the use of unwanted treatments. Mental health providers have recognized the persistent "revolving door" problem that impacts patients who have been subject to frequent and repeated involuntary hospitalization.[123] However, it is not always the case that patients are resistant to treatment, it can be resistance to the depersonalization and loss of control that comes with inpatient psychiatric care.[124] For some individuals, the ordeal of involuntary hospitalization can be incredibly frightening. One woman, speaking under the pseudonym "Y," detailed her experience with involuntary hospitalization for The Marshall Project in order to highlight disparate rates of forced psychiatric treatment for Black Americans.[125] She recounted that the morning before her hospitalization she noticed her speech

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118 *Id.*

119 *Advance Directives*, Ill. Dep't Pub. Health, https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives.html [https://perma.cc/QN2R-P7XZ] (last visited Feb. 12, 2023).

120 755 Ill. Comp. Stat. Ann. 43/30(4).

121 755 Ill. Comp. Stat. Ann. 43/50.

122 Ga. Code Ann. § 37-11-9 (2022).

123 Elizabeth M. Gallagher, *Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals*, 4 Psych. Pub. Pol'y & L. 746, 746 (1998).

124 *Id.* at 747.

125 Christie Thompson, *When Going to the Hospital is Just as Bad as Jail*, Marshall Project (Nov. 8, 2020), https://www.themarshallproject.org/2020/11/08/when-going-to-the-hospital-is-just-as-bad-as-jail [https://perma.cc/V4B2-9PTA].

"quickening," a symptom she recognizes as part of her bipolar disorder.[126] Later that day, she called the police when her ex-husband and children did not come home at the time she expected.[127] When the police arrived at her home, she was handcuffed and transported to a psychiatric hospital where she claims a nurse injected her with antipsychotic drugs under restraint.[128] Y stated: "'It was by far the most traumatic experience I've ever had in my life.'"[129] Stories like Y's are not uncommon, and highlight the important role that PADs can play for individuals and communities to reduce instances of coercive treatment. The hope is that PADs can help to lessen the dehumanization and disconnection that an individual may feel during treatment.

In a 2006 survey led by Dr. Jeffrey Swanson, it was found that people who had past adverse experiences being pressured into treatment felt an increased motivation to complete PADs.[130] Demographic characteristics were also found to correlate with a greater interest in PAD completion.[131] Specifically, those who identify as women and that belong to a racial minority had a greater probability of demand for a PAD.[132] The use of PADs has shown a positive correlation to providing better outcomes for patients and has the potential to reduce the likelihood of crisis intervention.[133] In another study conducted by Swanson in 2008 through the Duke University Medical Center Department of Psychiatry & Behavioral Sciences, he found that PADs reduced rates at which coercive crisis interventions ("CCIs") were used.[134] The study was performed by offering PAD templates to a sample of 239 patients, of which, 60% chose to complete them.[135] The study took place over a twenty-four month observational period with intermediate interviews at the six, twelve, and twenty-four month time periods.[136] The results showed evidence that advising patients of these rights, and making them procedurally available could significantly reduce the risk of a traumatic and unwanted intervention. During the first six months of

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126 *Id.*

127 *Id.*

128 *Id.*

129 *Id.*

130 Jeffery Swanson et al., *Psychiatric Advance Directives Among Public Mental Health Consumers in Five U.S. Cities: Prevalence, Demand, and Correlates*, 34 J. Am. Acad. Psychiatry L. 43, 54 (2006).

131 *Id.* at 53.

132 *Id.*

133 *See id.*

134 Jeffrey W. Swanson et al., *Psychiatric Advance Directives and Reduction of Coercive Crisis Interventions*, J. Mental Health 255, 265 (2008).

135 *Id.* at 257.

136 *Id.* at 260.

the study, only 6.5% of PAD completers experienced CCIs compared to 19.7% of non-completers.[137] Though by the twenty-four month mark the results became attenuated and could not be considered statistically significant, PAD writers still had a cumulative rate of CCIs at only 18.8% compared to 27.3% for the non-completion group.[138] Swanson concluded that these results indicate PADs have great potential for empowering patients.[139] He believes that in the long-term, fewer coercive practices in treatment helps to enhance patients' sense of self-determination and autonomy.[140]

3. Flaws and Complications

Though PADs show great promise for broader use and application, they also face criticism. One of the most common complaints is that they are unable to adequately cover the vast range of situations that can arise when an individual is experiencing a mental health crisis.[141] In her article, "Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals," Elizabeth Gallagher notes that "[e]ven a carefully drafted instructional directive may be challenged on grounds that the declarant failed to anticipate all of the available therapeutic options."[142] Gallagher also highlights that a patient's financial resources coupled with regulations imposed by third-party insurers and medical providers can make it difficult to ensure that all the patient's PAD requests will be honored.[143] There are also concerns that laws currently in place cannot adequately address the wishes written in people's advance directives due to conflict between the interests of the state and the individual writers.

State laws give fairly broad authorization for doctors to override an advance directive if the treatment requests conflict with a physician's standard of care.[144] This diminishes the potency of directives as they can be cast aside based on an individual physician's discretion. In doing so, the physician is somewhat disregarding principles of informed consent because the patient would not choose to undergo the treatment if they were not incapacitated.[145] This contributes to the historic disempowerment traditionally

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137 *Id.* at 261.

138 *Id.*

139 *Id.* at 265.

140 Jeffrey W. Swanson et al., *Psychiatric Advance Directives and Reduction of Coercive Crisis Interventions*, J. MENTAL HEALTH 255, 265 (2008).

141 Gallagher, *supra* note 123, at 750.

142 *Id.*

143 *Id.* at 773.

144 Swanson, *supra* note 96, at 385.

145 *Id.* at 386.

experienced by patients in mental healthcare settings and can devalue their personal autonomy. Further weakening the utility of a PAD, is the fact that civil commitment laws have greater power in nearly every United States jurisdiction.[146] This relates to the *parens patriae* interest that the government has in promoting what they interpret to be the welfare of society, even at the expense of individual liberty."[147]

B. *Relationships Between Family Involvement and Mental Health Treatment*

This Note will now go on to analyze the impacts family involvement can have in relation to mental health treatment. The goal of this section is to provide understanding for the reasons why a person may seek their family's input when deciding upon components of a PAD, as well as the possible benefits for their recovery. However, this section will importantly note that not all people desire input from their family members regarding their mental healthcare. In some situations, family involvement can be harmful, which is why this Note's proposal will apply only to those specific individuals who seek family participation.

1. Why is Family Involvement Important?

For individuals living with serious mental health illnesses, family support can be vital. While recovery from serious mental illness does not necessarily assume a complete remission of symptoms as it may be inferred in the medical context,[148] recovery can mean a significant improvement in one's wellbeing. In the early years of the field of psychology, parents and other family members were largely seen as the cause of trauma and a trigger for a person's mental illness.[149] However, this ignores the support that family relationships can provide for many individuals. Several studies have examined the benefits that family support and involvement in the mental health treatment process can have.

In a structured interview-based study of 169 people attending community treatment programs for serious mental illness, results showed that family involvement can have a positive influence on

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146 *Id.*

147 Ferris, *supra* note 66, at 966.

148 Susan Waller et al., *Family-Focused Recovery: Perspectives from Individuals with a Mental Illness*, 28 Int'l J. Mental Health Nursing 247, 247 (2019).

149 *Id.* at 248.

an individual's recovery.[150] Participants volunteered to answer questions to measure dimensions of functioning which assessed: quality of life, recovery, program participation, and levels of social support networks.[151] The study revealed that perceived reciprocity in relationships accounted for a 20% variance in recovery scores, which was attributed to the idea that "[c]onsumers who perceived themselves as engaged in greater reciprocal family support were more willing to seek help or assistance."[152] Another interview-based study of fifty-four individuals living in Montreal with diagnoses of severe mental illness revealed similar results.[153] Specifically, it highlighted that practical family support in the form of financial and household assistance was of great benefit.[154] It also found that "the mere presence of family can often influence recovery without explicit effort."[155] This demonstrates that family support can come in many different forms. In another qualitative, anecdotal study of family-focused recovery, patients described the different types of contributions their families have made to their mental health recovery. They stated their families provided them with a greater sense of purpose, helped them to recognize their emotions, and provided essential social support.[156]

The results of these studies demonstrate that family involvement can be valuable for individuals suffering from chronic, serious mental illnesses. Furthermore, this implies that family involvement could be a natural component of a person's mental healthcare treatment and recovery. Though family members may not be directly included in therapy or other treatments, they can help a person's outlook when planning for the future. Therefore, family dynamics could factor into PAD formation; however, this will depend on the individual and the historical context of their family relationships.

2. How Can Family Involvement Be Harmful?

While these studies show the positive potential family support has for those who seek and desire their family's involvement, many people who may have difficult relationships with family may see their involvement as a source of stress and conflict. The study discussed previously in Section III(B)(1) also addressed the limits of broad

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150 *See* Pernice-Duca, *supra* note 12, at 16, 23.

151 *Id.* at 16.

152 *Id.* at 22.

153 Heather Michelle Aldersey & Rob Whitley, *Family Influence in Recovery from Severe Mental Illness*, 51 Cmty. Mental Health J. 467, 471 (2015).

154 *Id.*

155 *Id.*

156 Waller, *supra* note 148, at 250–51.

family involvement by including personal anecdotes from participants who had less positive associations with their family members.[157] One participant, a sixty-one-year-old woman named 'Francine,' noted that the stigmatization she experienced from her family regarding her mental illness presented a major barrier to her recovery.[158] For others, their family's involvement in their mental health treatment had distinctly negative implications on their relationships. One man, a forty-year-old named George, stated that his sisters had conspired against him to force his hospitalization.[159] For people like George and Francine, these difficulties can lead to them to look outside their family for support. They may feel betrayed by family members who seek to initiate treatment or force hospitalization against their wishes.[160] Furthermore, this demonstrates that family involvement is primarily beneficial when the individual desires it.

IV. Proposal

This section restates this Note's proposal; for specific circumstances where a person has a strong family network and values their family's opinion when making decisions relating to their future mental health care, mediation can be used as a tool to facilitate a structured dialogue when considering components to include when a person establishes a PAD. This section will detail the incentives for applying family mediation to the PAD document conceptualization and formation process. It will then consider the limitations that this proposal has for real-world implementation.

A. *Mediation as a Tool for Facilitating Productive Family Discussions for PAD Decision-Making*

Based on research finding significantly positive impacts family involvement can have for some people who suffer from serious mental illness, it makes sense to consider that family members could productively assist in the creation of their loved one's PAD. At the same time, there is a delicate line a family must balance to ensure they do not overwhelm the principal and cause them to feel as though they

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157 Aldersey & Whitley, *supra* note 153.

158 *Id.* at 472.

159 *Id.* at 473.

160 *Id.*

are being forced into decisions they would not reach independently. This is where mediation could help to play a role in this process. Though a PAD is created to express individual preferences and desires, one cannot deny that when there are close bonds, familial relationships will be greatly impacted by the healthcare choices a person makes. Some experts in the field of mental health law have even asserted that exclusively focusing on patient autonomy and ignoring family input in advance care planning disputes is insensitive to the potential harm that can be caused to family dynamics.[161] Facilitating a structured dialogue where all parties can bring forward concerns in an organized, goal-oriented manner could be a beneficial strategy for PAD creation when patients seek their family's involvement. At the same time, the civil rights and autonomy of the individual must remain a priority.

The American Arbitration Association defines mediation as "an informal negotiation assisted by an impartial third party (the mediator) that encourages disputing parties to craft their own solutions."[162] In the case of family mediation for PADs, the idea is that a neutral third party would sit down with individuals seeking these structured dialogues to help guide the flow of ideas and keep the parties on task. Mediation for PAD creation could follow a format of traditional family mediation, but with an approach that places a heightened emphasis on the self-determination of the patient. This person-centered approach to mediation was previously proposed by attorney Matthew Bierlein for families making end-of-life care decisions in his article, "Seeing the Face of the Patient: Considerations in Applying Bioethics Mediation to Non-Competent End of Life Decisionmaking."[163]

B. *Incentives for Using Mediation*

Including a mediator to facilitate family discussions during PAD formation could be a great tool to ensure that the decision-making process centers the needs of the individual while simultaneously allowing family to voice relevant concerns in a productive manner.

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161 Thomas L. Hafemeister, *End-of-Life Decision Making, Therapeutic Jurisprudence, and Preventive Law: Hierarchical v. Consensus-Based Decision-Making Model*, 41 Ariz. L. Rev. 329 (1999).

162 *Mediation*, A.B.A., https://www.adr.org/Mediation [https://perma.cc/WL49-QHUV] (last visited Feb. 12, 2023).

163 Matthew Bierlein, *Seeing the Face of the Patient: Considerations in Applying Bioethics Mediation to Non-Competent End-of-Life Decisionmaking*, 23 Ohio St. J. Disp. Resol. 61, 84 (2007).

For these specific situations where an individual seeks their family's input, there can be a greater chance to avoid feelings of "hostility, guilt, fear, depression, and suspicion" that are the common results of a poorly managed conflict.[164] In his article, Bierlein proposes that person-centered mediation can be applied to conflicts surrounding end-of-life ("EOL") decision-making. Bierlein highlights that mediation is appropriate for families involved in care disputes because they are not binary issues and can have multiple different outcomes.[165] The same is true for advanced psychiatric care planning. With so many variations in the scope, duration, invasiveness, and other aspects of mental healthcare, family discussions could easily become disorganized and cause the individual stress as several parties seek to have their voices heard. Applying a form of person-centered mediation like the kind proposed by Bierlein, could help to ensure that mediation centers a patient's autonomy while still hosting an effective dialogue.[166] This would allow the individual writer to take into consideration the concerns of their family at the time they craft their PAD and also give the individual an opportunity to express their values and concerns in a manner that amplifies their voice. In addition, simply operating outside of traditional judicial processes could further help to uphold individual autonomy as traditional systems often operate in a standardized way that typically treats all individuals deemed incapacitated in a similar manner.[167]

Mediation has also previously been proposed as a process that can be used to assist conflict resolution in involuntary psychiatric treatment disputes between doctors and patients, as well as patients and their families.[168] Since mediation requires the consent and willing participation of both parties, it creates a dynamic less prone to feelings of distrust or coercion.[169] As long as the patient is able to actively engage in and make informed decisions regarding their care, there is no reason that they could not participate in a successful mediation.[170] In his note that proposes applying a mediation approach to representing clients during civil commitment proceedings, Henry Chen emphasizes that conducting family mediation with mental health patients can be

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164 Deborah Gentry, *Advanced Medical Directives and Family Conflict: A Potential Opportunity for Mediator Intervention*, 13 MEDIATION Q. 115, 120 (1995).

165 Bierlein, *supra* note 163, at 84.

166 *Id.* at 87.

167 Malorie Peacock, *Grandma Should Get a Voice Too: Mediation as a Tool for Dealing with Diminished Capacity Over Time*, 20 ALT. RESOL. 12, 14 (2011).

168 Henry Chen, *Current Development 2005-2006: The Mediation Approach: Representing Clients with Mental Illness in Civil Commitment Proceedings*, 19 GEO. J. LEGAL ETHICS 599, 611 (2006).

169 *Id.*

170 *Id.* at 610.

essential for maintaining family relationships and can benefit the long-term health of the patient.[171] Additionally, given the fact that PAD formation is likely to be a less urgent situation than decision-making at the time of involuntary treatment, the emotions of all parties may be less volatile.

A qualitative study that examined the effectiveness of Family-Centered Support Conversations for young adults living with mental illness demonstrates the potential that guided conversations can have for facilitating effective communication among family members.[172] Family-Centered Support Conversations were guided dialogues conducted by the researchers among family groups, which involved discussions about their experiences in their family's structure, the impact of mental illness in their lives, and ideas for support strategies in the future.[173] Through interviews with the families involved, researchers concluded that the guidance from third-party health care professionals allowed patients to feel "more confident about including family members."[174] They highlighted that the presence of a neutral third party leading discussion was important and helped keep family members on topic.[175] This finding can be applied to the use of mediation as proposed by this Note.

Furthermore, given the past research that has demonstrated the positive influences increased autonomy, family involvement, and guided family conversation have had for individuals with mental illnesses, implementing mediation for PAD creation could assist these processes.

C. *Limits of Mediation's Applicability*

Mediation can be a useful asset in advance care planning, but it is also limited in its reach as it must be facilitated in a manner that is appropriate for varied and complex family dynamics. The primary barrier that stands in the way of broadly applying family mediation for PAD creation is that all parties must come to mediation voluntarily. Self-determination is a central tenet of mediation, which means that a party has the ability to leave mediation if they choose

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171 *Id.* at 611.

172 Lisbeth Kjelsrud Aass et al., *Young Adults and Their Families Living with Mental Illness: Evaluation of the Usefulness of Family-Centered Support Conversations in Community Mental Health Care Settings*, 26 J. Fam. Nursing 302, 308–09 (2020).

173 *Id.* at 304.

174 *Id.* at 308.

175 *Id.* at 309.

to do so.[176] Therefore, if a principal is resistant to the mediation process, they cannot be compelled to participate. This limitation will constrain the reach of this proposal because individuals in care-related disagreements with their families may be highly resistant to their involvement.

Another major limitation to implementation is that effective participation in mediation requires a person to have the ability to make informed decisions about their care.[177] This means they must be in a mental state that allows them to communicate their wishes to their fullest extent. However, even in the case that someone is experiencing an acute mental health crisis, mediation can be postponed, and the PAD can be formed at a later date. This is because mental health crises are often temporary and are not likely to prevent a person from participating in mediation once they are in a lucid state.[178] This distinguishes this Note's proposal from that of Bierlein's end-of-life proposal,[179] because unlike many end-of-life care cases, the PAD patient population is not typically facing a form of predictable, progressive decline.

Furthermore, determinations of capacity will have to be made on a case-by-case basis. Some individuals living with serious mental illness may not be able to recognize their diagnosis or its severity in a way that would allow for effective communication during mediation. A condition called anosognosia is estimated to impact around 30% of people diagnosed with schizophrenia and 20% of people with bipolar disorder.[180] This condition makes it difficult for person to have insight into their condition or be aware of it.[181] Therefore, mediation could only be applied in cases where a person has a suitable level of understanding around their diagnosis in order to participate. It is also important that the mediators facilitating the mediation process have extensive experience working in a mental health setting or with mental health advocacy. This is to ensure the mediator is well equipped to handle and understand the challenges that can arise in these mediations.

A further limiting factor that could negatively impact the PAD principal during mediation is a power imbalance within the family.

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176 *APFM Standards of Practice for Professional Family Mediators*, Acad. Pro. Fam. Mediators (Feb. 2, 2014), https://apfmnet.org/standards-practice-professional-family-mediators/ [https://perma.cc/QEK9-T2Z7].

177 Chen, *supra* note 168, at 610.

178 *Id.*

179 *See* Bierlein, *supra* note 163.

180 Esmy Jimenez, *Why it's Often Hard for People to Recognize Their Own Mental Illness*, Seattle Times (Jan. 3, 2022, 6:00 AM), https://www.seattletimes.com/seattle-news/mental-health/why-its-often-hard-for-people-to-recognize-their-own-mental-illness/ [https://perma.cc/QE3R-XJBP].

181 *Id.*

Especially in mediations where an individual is unrepresented by counsel, there is concern that these dynamics can lead an individual to be taken advantage of.[182] Because of this, some mediation professionals recommend that an attorney is hired after mediation concludes to review any agreements created during the mediation, but prior to the parties signing any documents.[183] However, even if this practice were to be employed, it is still important that parties enter into mediation without representation, as it allows the process to remain non-adversarial.[184]

V. Conclusion

Over the past two centuries, society's approach to treating mental illness has changed drastically. Originating as a system of social ostracism that failed to acknowledge any right to individual liberty, mental health law has evolved to allow individuals to express their treatment ideals through PADs before psychiatric care even begins. Psychiatric advance directives provide a powerful tool for advancing patients' rights to autonomy. As proposed by this Note, mediation can be used as another tool to help people living with serious mental illnesses form PADs where their families have historically been positively involved in their mental health treatment. Mediation can help PAD writers to feel supported as they work to treat their mental health, and in crisis situations where they may be unable to adequately express their preferences for treatment. This form of mediation can apply where a person seeks their family's contribution to the decision-making process and when all parties come into the process voluntarily. At the same time, there may be limited applicability. This is because PADs are still not widely used, and many family dynamics will not be conducive to creating an effective discourse for mediation.

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182 *See* Mary Kay Kisthardt, *The Use of Mediation and Arbitration for Resolving Family Conflicts: What Lawyers Think About Them*, 14 J. Am. Acad. Matrim. L. 353, 374 (1997) ("Because clients vary in their abilities to represent themselves well, attorneys are justifiably concerned that some may be taken advantage of in a process where they have no 'advocate.'").

183 *Id.*

184 Sharon L. Flower, *Resolving Voluntary Mental Health Treatment Disputes in the Community Setting: Benefits of and Barriers to Effective Mediation*, 14 Ohio St. J. Disp. Resol. 881, 903–04 (1999).