Statutes Governing Default Surrogate Decision Making for Mental Health Treatment

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Objective: The authors sought to describe state-to-state variations in the scope of statutory authority granted to default surrogates who decide on mental health treatment for incapacitated patients.

Methods: The authors investigated state statutes delineating the powers of default surrogates to make decisions about mental health treatment. Statutes in all 50 U.S. states and the District of Columbia were identified and analyzed independently by three reviewers. Research was conducted from August 2017 to November 2018 and updated in January 2020.

Results: State statutes varied in approaches to default surrogate decision making for mental health treatment. Eight states' statutes delegate broad authority to surrogates, whereas 25 states prohibit surrogates from giving consent for specific therapies. Thirteen states are silent on whether surrogates may make decisions.

Conclusions: Heterogeneity among state statutory laws contributes to complexity of treating patients without decisional capacity. This variability encumbers efforts to support surrogates and clinicians and may contribute to health disparities.

Psychiatric Services 2021; 72:81–84; doi: 10.1176/appi.ps.201900320

Mental illnesses are a leading cause of global disease burden and are distinct from many other health conditions in that they directly involve an individual's cognitive processes, emotional regulation, and behaviors. Lived experience with mental illness may affect one's thoughts, beliefs, perceptions, feelings, motivations, decisions, and actions (the sine qua non of individuality and self). Conditions such as major depressive disorder, schizophrenia, substance dependence, and dementia can impair a patient's decision making both over the course of a psychiatric episode and to varying degrees over time (1). Severe depression can be associated with negative cognitive distortions, hopelessness, and social and emotional disengagement, including inability or refusal to participate in assessment or treatment decisions (1).

Disorders along the psychosis spectrum can manifest as difficulties in organizing thoughts, reasoning, evaluating situations, building good reality-testing habits, and trusting others because of troubling thoughts or fears (2, 3). For these reasons, decision making in the context of psychiatric disorders may be more nuanced than in the context of other health conditions. Patients with mental illness who lack sufficient capacity to make decisions may be unable to direct the course of their own medical and psychiatric care. Unfortunately, such circumstances are not uncommon. For example, although a relatively small percentage of persons with mental illness receive inpatient treatment, as many as 45% of psychiatric inpatients may not be capable of making treatment-related decisions (2, 4).

Individuals may direct some aspects of their care in the event of future incapacitation by indicating treatment preferences or designating a decision maker via an advance directive. However, most Americans do not have such directives in place (5). Furthermore, although all states have statutes that articulate requirements for medical advance directives, only 25 states have enacted statutes that recognize and allow advance directives specific to psychiatric

HIGHLIGHTS

- In the event of a loss of decisional capacity, patients who do not provide advance directives or a health care power of attorney must often rely on default surrogate decision makers.
- State statutes vary widely in the extent to which they permit default surrogates to make mental health treatment decisions on behalf of incapacitated patients.
- Statutory variability among states has important implications for patient care and may contribute to health disparities nationally.

illness and treatment (6). In states that do allow psychiatric advance directives, prevalence and effectiveness in inpatient settings have not been systematically reported.

In the absence of an advance directive or a judicially appointed guardian, the health care system commonly relies on default surrogate decision makers to protect the interests and well-being of individuals lacking sufficient decisional capacity (7). We use "default surrogate" to mean a person who assumes decisional authority without having been appointed through the judicial system or prospectively designated by a patient. In the United States, state legislatures have enacted a variety of statutory mechanisms for appointing default surrogates to safeguard decision making for incapacitated patients (7).

State statutory designs governing the appointment of default surrogates vary widely in scope and application. Several states require that the patient have a "qualifying condition" (typically either terminal illness or permanent unconsciousness) before default surrogate consent is authorized (8). These limitations restrict the domain of default surrogate consent provisions because many patients who lack decisional capacity are neither terminally ill nor permanently unconscious (8). The limited scope of decision making by surrogates is particularly true for patients whose lack of decisional capacity is caused by mental illness and who may, therefore, transiently but predictably lose and regain capacity at several points during their life (4, 5).

State statutes differ in the range of powers they delegate to default surrogates. Despite the important impact these laws may have in the context of mental health, this heterogeneity has not been systematically examined. In this report, we aim to describe the prevalence and contents of state statutes applicable to mental health default surrogacy.

METHODS

Three reviewers independently searched two legal databases (FastCase and LexisNexis) for statutes governing default surrogate decision making for mental health in all 50 U.S. states and the District of Columbia. In instances requiring further clarification, the reviewers examined state legislative websites and other online databases of state statutory law. In each state, we examined the state's general default surrogate law (if any), the state's mental health act (if any), and the remaining corpus of state statutory law pertaining to default surrogates for health care. Search terms included "mental health," "psychiatric treatment," "consent," "alternate decision maker," and "surrogate," along with specific mental health treatment terms commonly encountered in these statutes, such as "electroconvulsive therapy," "psychosurgery," and "psychotropic medication." We tabulated our search results and categorized exceptions to a default surrogate's statutory authority to make decisions about mental health care by both the scope of default surrogate authority and type of decision or treatment. All analyzed statutes were effective in their jurisdictions as of January 15, 2020.

RESULTS

State statutory approaches to default surrogate decision making for mental health fell into four broad categories. First, some jurisdictions' statutes allow default surrogates to make any and all mental health treatment decisions the patients themselves could have made. A second group of states is more restrictive, carving out statutory exceptions to the default surrogate's authority for decisions involving specific types of mental health treatment, such as electroconvulsive therapy. A third group of statutes explicitly prohibits a default surrogate from making any decisions about mental health care whatsoever, and the final set of state statutes is silent as to default surrogate decision making for mental health.

Eight states (16%) allow unrestricted decision making for mental health care by a default surrogate (see online supplement). These jurisdictions empower the default surrogates to make any treatment decision the patients themselves could make regarding their own mental health care, if they were able to do so (e.g., Arkansas: "A surrogate who has not been designated by the principal may make all health care decisions for the principal that the principal could make on the principal's own behalf") (9). In these states, the default surrogate statute expressly permits consent for mental health treatment or includes mental health within the statutory definition of "health care," "medical treatment," or similar terms (e.g., according to South Carolina, "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care that may be extended to a patient to diagnose and treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin; treatment includes, but is not limited to, psychiatric, psychological, substance abuse, and counseling services) (10).

The statutes of 25 states and the District of Columbia (51%) permit a default surrogate to make some decisions about mental health care on behalf of an incapacitated patient but restrict other interventions. These statutes include exceptions to the default surrogate's decisional authority to authorize certain specific types of mental health treatment or to consent to an incapacitated patient's admission to a mental health treatment facility.

The statutes of four states (8%) have blanket prohibitions against mental health treatment decisions by default surrogates. In these jurisdictions, default surrogates are prohibited from making decisions about any kind of mental health care on behalf of the incapacitated patient.

Finally, the statutes of 13 states (25%) do not address whether a default surrogate may make treatment decisions for mental health care. In these jurisdictions, the definitions of medical treatment in the general surrogate law (if any) do not specifically include mental health. Further research did not reveal any other indication in state statutory law, including in the state's mental health act, that a default surrogate would be either permitted to authorize mental health

treatment on behalf of an incapacitated patient or explicitly prohibited from doing so.

Among the 25 states and the District of Columbia with statutes that provide exceptions to a default surrogate's decisional authority for mental health, the ability to consent to some interventions is routinely and specifically prohibited. These states generally restrict default surrogate consent to electroconvulsive therapy (14 states and the District of Columbia; 58%), psychosurgery (13 states and the District of Columbia; 54%), admission to a mental health facility (17 states; 65%), and administration of neuroleptic medication (seven states; 27%). The statutes of 18 states (69%) restrict consent to more than one of these therapies. Altogether, the statutes of 30 states (59%) either prohibit default surrogates from making mental health treatment decisions or restrict the types of mental health treatments that such surrogates may authorize.

DISCUSSION

There is broad ethical and legal agreement that default surrogates may make medical decisions for patients who lack decisional capacity, including, in many jurisdictions, withholding or withdrawing life-sustaining treatment. This accord is reflected in states' statutory default surrogate laws for medical decision making. Although all 50 states and the District of Columbia address decision making for incapacitated patients in some general circumstances, not all have a mental health–specific statutory provision (7). Significant statutory variability reveals a lack of consensus regarding surrogate decision making in the context of psychiatric illness; this variability holds important implications for patient care and may contribute to health disparities.

For example, Arkansas's statutes permit a default surrogate to consent to any and all mental health treatment on behalf of an incapacitated patient (9, 11). The neighboring state of Louisiana, however, forbids all default surrogate decision making for mental health (12). As a result, patients with mental illness and without decisional capacity who are hospitalized in Arkansas without having provided an advance directive may have treatment decisions made on their behalf by a default surrogate (often a close family member) who knows them and is familiar with their values and preferences. In Louisiana, however, these decisions would likely be made by a patient's attending physicians or a judicially appointed guardian, none of whom are likely to know the patient well, if at all.

Notably, many states with statutes that either restrict or completely prohibit default surrogates from making mental health treatment decisions simultaneously allow default surrogates to authorize the withdrawal of life-sustaining treatment. If default surrogates are authorized to make life-and-death decisions on behalf of incapacitated patients in many jurisdictions, why have some of these same states restricted surrogates' decision making about mental health? Whether such restrictions are justified in light of current understandings about the biological bases for psychiatric illness and modern treatment methodologies warrants further study.

Although statutes govern important elements of default surrogate decision making for mental health treatment in many jurisdictions, it is critical to note that legislation is not the only source of relevant law in each state. In some instances, state judicial decisions (case law) may also set parameters for decision making by default surrogates on behalf of incapacitated persons with mental illness. For example, although research did not reveal any relevant Massachusetts statute regarding default surrogate decision making for mental health, a 1983 Massachusetts Supreme Court case held that "a distinct adjudication of incapacity to make treatment decisions (incompetence) must precede any determination to override patients' rights to make their own treatment decisions" (13). Although a comprehensive review of state case law is beyond the scope of this report, practitioners must be cognizant of the full corpus of state law in their jurisdictions when ascertaining the extent to which default surrogates may participate in decisions about mental health treatment.

CONCLUSIONS

A substantial majority of state jurisdictions include a provision for appointment of a default surrogate for at least some health care decisions, thereby legally recognizing the decisional authority of default surrogates and providing a safety net for incapacitated patients without advance directives (7). Despite the wide latitude afforded to default surrogates in medical decision making, the statutes of 30 states (59%) either prohibit default surrogates from making mental health treatment decisions altogether or restrict the types of mental health treatments that such surrogates may authorize.

Although decision making in the context of psychiatric illness can be challenging (14), restrictions on default surrogate authority may run counter to current understandings of psychiatric illness as biologically based and responsive to medical, pharmacological, and (in some cases) procedural interventions. It is unclear whether these restrictions arose in reaction to historical misuse and abuse and a principled desire to protect individuals at the most vulnerable moments of their lives or resulted from thoughtful and reasoned legislative deliberation. In addition, preliminary empirical findings suggest that the use of surrogate decision makers as a safeguard is not highly endorsed by individuals with diverse psychiatric and physical disorders (15), indicating the imperative to find more patient-centered practices and policies to ensure that patient preferences are honored and patient rights are protected.

State-to-state variations in default surrogate decision making for mental health have important implications for individuals living with mental illnesses. National efforts to destigmatize mental illness and improve patient care must

include robust discussion and evaluation of the role of default surrogates and other potential safeguard strategies in making treatment decisions for this vulnerable population.

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Dr. Roberts reports grants from the National Institute of Mental Health, the National Institute on Aging, and the National Human Genome Research Institute. Dr. Kramer reports grant funding from the Greenwall Foundation.

Dr. Roberts reports ownership of Terra Nova Learning Systems. She also serves as a consultant for federally funded scientific projects across the United States, as editor-in-chief of the Books Department of American Psychiatric Association Publishing and for the journal *Academic Medicine* (funds for these duties are provided to Stanford University), and as an adviser for the Bucksbaum Institute of the University of Chicago Pritzker School of Medicine. Dr. Mueller reports receiving consulting fees from the Boston Scientific Patient Safety Advisory Board and personal fees from the *NEJM* Journal Watch General Medicine (for which he is an associate editor) and the American College of Physicians. The other authors report no financial relationships with commercial interests.

Received June 26, 2019; revision received May 29, 2020; accepted June 4, 2020; published online October 14, 2020.

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