**Planning for Mental Illness Flare-Ups**

**By Shawn Majette, Esq.**

Special needs planning for a loved one with mental illness is complicated. Symptoms tend to wax and wane. This makes it difficult to balance protection and security with an individual's right to privacy and independence. The key is to design legal instruments that adjust to changing circumstances.

Families can often predict the likelihood of flare-ups based on a person's history, the need for occasional adjustments to medication, or published mental health statistics. In most cases, most of the time, standard advance directives can be helpful. These give trusted individuals the authority to make healthcare and legal decisions on the person's behalf, especially during periods of vulnerability. They are lifesavers when doctors need to know who is legally recognized to speak for a patient who lacks capacity.

Because life changes life, advance medical directives can be changed when life changes. Agents can be added and removed at will. The patient can revoke an advance medical directive.

Problems arise with a standard advance directive when a mental disorder clouds judgment to the point where distrust, delusion and paranoia turn the agent into a perceived threat. An agent attempting to exercise the agency for the patient's good can be thwarted by the simple revocation of the advance directive, since the grantor, until established to the contrary, has the right to rescind powers in the advance directive.

**Healthcare**

Individuals with mental illness, who have been through the wringer and, aware of both the horror of the disease and the legal process which can be required to protect them, want to avoid it, can create special advance directives available in many states.

These instruments recognize that the grantor can anticipate psychiatric care at times when the person's decision-making is compromised, and allow for limited authority of the agent to make decisions which the grantor protests. The authority can (and in my judgment, should) specifically allow for protested hospitalization *and* therapies, usually including anti-psychotic medicines and electro-convulsive therapy (ECT).

Simply stated, these instruments allow grantors with mental illness to appoint *their own* preferred agent to make highly personal and deeply invasive decisions. In doing so, they can minimize the risk of crisis-driven and public incapacity hearings.

These instruments, available in a growing number of states, are called **psychiatric advance directives (PADs)**.

A PAD enables them to authorize a trusted agent to make healthcare decisions which may conflict with wishes they express during a mental health episode. This includes the possibility of temporary admission to a psychiatric institution in which their liberty can be restricted with physician approval. A PAD can, and often should, express the grantor's preferences for medications and treatments to be provided or avoided. In some states, a PAD must be periodically renewed.

**Financial Decisions**

Another common concern is that someone will be financially intemperate – a spendthrift – in a spell of illness. When individuals recognize that the illness can lead to this disaster, they can protect themselves and their assets with a revocable **self-settled** trust in which the trustee is given discretion to judge whether the grantor is acting irrationally. "One new Mercedes," the trustee might have said in an actual case known to me, "is agreeable, Peter, but not the other three for your waitresses in the new tavern you've just obligated yourself to buy."

In such trusts (which I've called "**in-out trusts**"), when the trustee thinks the grantor's **in** *his* right mind, the trustee complies with the grantor's decisions. Only when the grantor is **out** of his right mind does the trustee trigger a discretionary cooling off period. During the cool-down, the trust is used to take care of the grantor's needs and reasonable extras (gas for one Mercedes).

If the cool-down time is sufficient, life ticks on when the grantor is recovered and everyone is happy. If reason takes a longer powder than the cool-down period, the trustee has various options spelled out in the document. These can include payment into court or as directed by a guardian, conservator or a trust protector.

Because these are simple variations on an option that's available throughout the U.S., any good trust lawyer can draft them. They can be created by the person with mental illness (which is better) or that person can authorize an agent to create one. The latter course is not preferred.

It's important to note that because these trusts are revocable, if the individual requires means-tested government benefits such as Medicaid, the assets they hold are considered

resources when determining program eligibility. When disability exists and the grantor is under 65, a "nested" irrevocable trust with mandatory payback nestled *within* the in-out trust can be made. That's a little complex for this article, but it can be done.

While an in-out trust grants the trustee sole authority to distribute its funds, it can be amended or canceled at any time, *except during a mental illness episode*. This, in many cases, protects funds from being dissipated during a bad spell. The beneficiary typically must provide written notice of an intention to change or revoke the trust, which provides the trustee with an opportunity to refuse to comply if concerned about the individual's mental state. In such cases a cooling off period begins, during which the flare-up may end. If the parties remain at odds, the trustee can be authorized to seek guidance from the courts, including the potential naming of a guardian/conservator.

If, however, the beneficiary enters into a contract during such periods (to purchase all those Mercedes, for instance), he will ultimately remain liable for the debt unless he can establish a good defense to the car dealer. In some states, only a **self-settled spendthrift trust** (which is, by definition, irrevocable) protects against future creditors.

In the center of the universe (Virginia, my home), for instance, the burden of proof falls to the individual to establish that he was incapacitated at the time he entered into the contract, and this can be difficult to establish. Still, federal law protects certain assets from creditors' process (garnishment, involuntary seizures, etc.) if they are kept separate within the trust. Personal injury or workers compensation settlements, SSI (Supplemental Security Income) and certain other resources can be guarded in that manner.

Given the serious responsibilities that the beneficiary confers with in-out trusts, it's advisable to have a qualified professional certify that he understands its implications at the time of signing. A doctor or social worker can be helpful. It may also be wise for the beneficiary and intended trustee to be represented by separate legal counsel while the agreement is being established.

**Other Financial Options**

Better protection from creditors *can* be obtained with an **uncontested conservatorship**, a sibling to guardianship discussed below. A conservatorship is a judicial declaration of incapacity. It must be made through the courts. This renders the individual unable to enter into contracts. It's an extreme measure, and the cure can be worse than the disease.

Funds originating with anyone *other* than the beneficiary can be protected in a **third party special needs trust (SNT)** created on his behalf. Creditors can't claim such resources, because the beneficiary never has direct access to them. The settlor, or fund creator, can formulate a letter of intent that provides guidance on making distributions, based on

the beneficiary's mental state and other behavior, such as the continued taking of doctor-prescribed medications. Properly written, assets in these trusts (which can be revocable by the settlor, but not the beneficiary) won't be counted when determining the beneficiary's eligibility for means-tested government benefits and will escape the maw of most creditors.

**Guardianship**

Most people with mental illness can live independently in the community, given therapy and medication. When, however, someone's condition consistently interferes with the ability to make decisions, guardianship is an option. Through guardianship, the court appoints an individual to be legally responsible for making certain choices on the individual's behalf, subject to periodic review. Because the process can be slow and is usually expensive, it's not the best option at any time, and especially during a crisis.

It's important to recognize the difference between "bad judgment" and incapacity. Guardianships should be as unrestrictive as possible, focusing only on those situations in which the person truly lacks comprehension. State statutes differ and should be consulted to determine how to best shape a guardianship decree in order to address the individual's specific needs. When I work with guardianships, I take special note of the following:

- Giving sole authority to the guardian/conservator to enter into binding contracts or make gifts.
- Providing for support to an individual's spouse and minor children.
- Limiting the guardian's liability to instances of his own negligence. Families are often concerned that the individual's behavior may leave them open to legal action.
- Ability of the guardian to admit the individual to a psychiatric facility and to require acceptance of prescribed medication, against the person's wishes, if necessary. In some of my guardianship orders (as well as psychiatric advance directives), I have included express authority to take control of the individual—or to engage third parties, such as law enforcement officers, to do so–in order to transport the individual to a hospital. State laws differ significantly in this regard. Each state has some form of involuntary civil commitment, but may not grant this authority to a guardian or if so, may require additional legal procedures or stipulate renewal periods.

**Last Resort**

There are, unfortunately, situations in which an emergency involuntary commitment becomes necessary. A court may order care upon receiving evidence that an individual

with mental illness poses a threat to himself or others. In all cases, the required treatment must be the least restrictive alternative and the period of confinement is limited.

The goal of special needs planning for individuals with mental illness should be to optimize their independence and safety. The more they structure protective mechanisms on their own behalf, the better, but there are also proactive steps that can be undertaken by those who love them. Crisis-driven decisions can be traumatizing for all concerned and should be avoided if at all possible.

Resources that I recommend to individuals with mental illness and their families are NAMI (National Alliance on Mental Illness), Treatment Advocacy Center and the Bazelon Center for Mental Health Law.

*Posted May 2018*

---