Testimony on LB 247
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Nebraska Legislature
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Good afternoon Senator Lathrop and members of the Judiciary Committee. For the record, my name is Brad B-R-A-D Meurrens M-E-U-R-R-E-N-S and I am the Public Policy Director for Disability Rights Nebraska, the designated Protection and Advocacy organization for people with disabilities in Nebraska. I am here in opposition to LB 247 as it is currently written.

Instead of advancing LB 247, we would strongly encourage the legislature to entertain a Legislative Resolution instead. Given the scope of authority granted by these directives, and the gravity of removing healthcare decision making authority, the legislature should slow down and engage stakeholders, professionals, advocates, and individuals who have a lived experience with psychiatric disabilities in a broader discussion about what are the key components that must be addressed in these directives. As those are the individuals who would be directly affected, they need to be included in the development of psychiatric advance directive legislation.

Our position stems not from opposition to the concept of psychiatric advance directives. Rather the language in LB 247 is often confusing and it raises additional questions about the nature and operation of these directives. For example, express authorization to the agent to consent to inpatient treatment or medication is not required to give the agent authority to consent to these treatments (page 5, lines 11-13); if the directive fails to address an issue, an agent shall make the decisions according to the principals instruction or preferences “otherwise known to the agent” and if these

instructions or preferences are not known, the agent gets to make the decisions anyway.

The Substance Abuse and Mental Health Administration identifies instructions and preferences commonly found in psychiatric advance directives such as[1]:

- **When to treat:** *"I authorize my agent to get me mental health help if I start to… order lots of stuff from TV ads… if I start hearing voices telling me to hurt myself…"*
- **Alternatives to hospitals:** *"I want to go to a crisis bed but not a hospital if I am feeling self-destructive."*
- **Knowledge of medication effects:** *"I will take this antipsychotic but have learned from past experience not to have a dosage over XYZ."*
- **Adverse actions:** *"I do not want injections because I am afraid of shots but I am OK with pills."*
- **Trauma concerns:** *"Because of past sexual abuse, I cannot be put into restraints. This would worsen my condition. Do this instead…"*
- **Treatment parameters for providers and agents:** *"I authorize my agent/provider to treat with anti-psychotics they decide on, but if I start exhibiting the following side effects, I want the medication reduced or stopped."*

Additionally in many states, it is a misdemeanor to:

- willfully conceal/cancel a psychiatric advance directive
- withhold knowledge of a revocation
- falsify a directive
- coerce execution of a directive

Few of these concepts are in this bill and for those that are, the language is thin, vague, and confusing. For example, individuals can choose "the standard by which the directive becomes active" (p. 2, line 30), but what is a "standard"? I would direct you to the New York Times article I have included—the article contains excerpts from advanced directives and demonstrates the inclusion of these types of treatment preferences explained in plain language.

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[1] https://www.samhsa.gov/sites/default/files/programs_campaigns/recovery_to_practice/pad-webinar-ppt.pdf

We also have concerns about the self-binding directive: that it has to be an irrevocable directive and if the principal disagrees with the instructions in the directive, or refuses treatment spelled out in the directive, that refusal is used to demonstrate incapacity.

On page 3, lines 20-21 an individual's capacity is evaluated "relative to the demands of a particular mental health care decision". What does that mean?   The definition of "capacity" seems to conflict with the treatment refusal trigger for self-binding directives.

We would like to see psychiatric advance directives in place in Nebraska. We just believe that this bill is not the vehicle at this time and issues need to be addressed in a broader discussion with a wider array of stakeholders—a Legislative Resolution not Legislative Bill.