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THE CHOICE TO LIMIT CHOICE: USING PSYCHIATRIC ADVANCE DIRECTIVES TO MANAGE THE EFFECTS OF MENTAL ILLNESS AND SUPPORT SELF-RESPONSIBILITY

Breanne M. Sheetz*

Psychiatric advance directives are a valuable tool for individuals with mental illnesses. Ulysses directives, in particular, allow individuals to bind themselves to treatment in advance of needing it for the purpose of overcoming illness-induced refusals. This Note evaluates the effectiveness of state advance directive statutes in three areas that are especially important for Ulysses directives: defining competency to execute, activate, and revoke directives; waiving the constitutional right to refuse treatment; and encouraging provider compliance. This Note ultimately advocates for other states to adopt provisions similar to a Washington State statute. The Washington statute authorizes Ulysses directives by allowing advance consent to treatment, establishing a mechanism for overriding refusals, and permitting irrevocability, but it also provides flexibility so that individuals can craft a personalized plan for their needs.

INTRODUCTION: JANE’S STORY

Doctors diagnosed Jane’s bipolar disorder after a severe manic episode that lasted for several months. She first experienced racing thoughts and excessive energy. Family and friends struggled to understand her because she spoke rapidly with disjointed thoughts. Jane began having delusions about herself and others, believing that she was a reincarnated savior and perceiving extreme good or evil in strangers. Her family tried to admit her to a psychiatric hospital, but the staff could not keep her because she refused to accept treatment and she was not technically a danger to herself or others. Through it all, Jane believed that nothing was wrong. Instead, she was exuberant about life and thought that she had discovered the secret of happiness.

As the illness progressed, Jane cut off all contact with family and friends because they could not appreciate her newfound happiness. She befriended a family of criminals, allowing them to stay in

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1. References to Jane’s story throughout this Note are based on the experiences of an actual person known to the author.
her apartment and buying them expensive presents. She stopped going to class and to work. Jane rarely slept or ate. Eventually, when she ran out of money, she became homeless and wandered all over the city, starting conservations with anyone who would listen, and getting into trouble with the police. After devastating nearly every aspect of her life, Jane’s delusions started crashing down around her. She was alone with no money and no support. Her family agreed to help her if she sought treatment, as they had maintained all along, and Jane finally admitted herself to an inpatient treatment program.

After recovering from the episode, declaring bankruptcy, rebuilding relationships with family and friends, finishing college, and returning to work, Jane decided that she never again wanted the illness to control her life. Unfortunately, she knew it was likely that, if she became manic again, she would experience the same loss of judgment and insight that had prevented her from seeing the truth about her condition the first time. Jane strictly adhered to her treatment plan, taking her medication and visiting her psychiatrist regularly. However, she still had a nagging fear that it would happen again. To allay her concern, she executed a psychiatric advance directive, a legal document that enabled her to plan her mental health treatment in advance. In Jane’s case, she gave prospective consent to hospitalization and medication for future manic episodes.

This Note addresses why and how psychiatric advance directives should be enforced when an individual with a mental illness, like Jane, requests hospitalization or other treatment in advance of needing it. Such a request is generally made because the individual foresees that she will refuse treatment during an acute episode. Some mental illnesses, such as bipolar disorder, cause the affected individuals to deny that they have an illness when they feel the effects most keenly. This lack of insight is a symptom of the illness, and the individual may wish to minimize the negative consequences by prescribing treatment in advance.

The first Part of this Note will briefly discuss why a person with a mental illness should be able to prescribe future treatment. The Note will examine arguments for this proposition, such as the benefits of early intervention and improved decision-making, as well as counter-arguments, which include the potential for abuse. This Note will then analyze the major barriers to enforcing psychiatric advance directives that prospectively request treatment. These challenges include competency assessments for individuals whose decision-making capacity varies over time and constitutional limita-
tions such as the right to refuse treatment. The majority of this Note will evaluate how effectively psychiatric advance directive statutes address the needs of individuals like Jane. This Note ultimately advocates for other states to adopt provisions similar to a Washington State statute, which permits advance consent to treatment, authorizes irrevocable directives, and establishes a mechanism for overriding illness-induced refusals of treatment, while also providing flexibility so that individuals can craft a personalized plan for their needs.

I. THE VALUE OF PSYCHIATRIC ADVANCE DIRECTIVES

Psychiatric advance directives are legal documents that enable individuals to plan in advance for mental health treatment. The directives can take several forms. One type, the instructional directive, allows individuals to provide directions about treatments that they would or would not like to receive while they are incapable of making treatment decisions. A second type, the proxy directive, permits individuals to appoint an agent to make decisions for them while they are incapacitated. Another type, the hybrid directive, contains elements of both instructional and proxy directives. A fourth type, the Ulysses directive, is most pertinent to individuals with episodic and insight-impairing illnesses like Jane’s because it enables them prospectively to bind themselves to treatment and override, in advance, their refusals during acute episodes of their illnesses. The name references The Odyssey, in which Ulysses, before sailing into the domain of the Sirens, directed his men to tie him to the mast of his ship so that he could listen to their irresistible song without throwing himself overboard, and commanded them to bind him more tightly if he demanded to be unbound. Analogously, Jane executes an irrevocable advance directive to ensure that she will receive treatment because she predicts that she

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3. Id. at 541.
4. Id.
will irrationally ask to be "untied" from her previously expressed wishes when she is manic.

A. More Effective Treatment

Fundamentally, psychiatric advance directives are valuable because they enable individuals with mental illnesses to obtain treatment that helps them manage their illnesses. Many individuals with mental illnesses can lead productive and satisfying lives, and their opportunity to do so increases with consistent treatment.\(^7\) Although psychiatric treatment does not cure chronic mental illness, it has the potential to "return an individual to a higher level of competency and social functioning."\(^8\) Individuals with mental illnesses often benefit from treatment. For example, in a review of thirty-eight studies of retrospective satisfaction with hospitalization, a researcher found that a majority of patients in thirty of the studies voiced favorable attitudes and claimed that treatment had helped them.\(^9\) Furthermore, early treatment can be crucial for minimizing the negative effects of an acute episode of mental illness.\(^10\) If Jane had been able to obtain earlier intervention during her first manic episode, then it likely would have halted the downward spiral that led to her bankruptcy, her damaged relationships, and her productivity and reputational losses at school and work. A Ulysses directive will enable her to receive beneficial early treatment and avoid these consequences in the future, even if another episode of mania causes her to refuse it at the time.

B. Better Decision-Making

Individuals with mental illnesses are in a better position to make reasoned decisions about their treatment when they are not acutely affected by symptoms of their illnesses. As one scholar explained the argument, "there is a 'true' or 'rational' identity best equipped to make long-term decisions for that person... The [advance directive] state would enforce the choices of this identity and

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disregard subsequent choices of the ‘mentally ill’ identity.”  For example, an individual with bipolar disorder, like Jane, might wish to prevent her manic self from making decisions regarding mental health treatment that would negatively impact the education, career, finances, and family relationships she values while she is well.

Mental illness is unique because affected individuals must learn to accommodate a “rational” self and a “mentally ill” self. Individuals with mental illnesses are often capable of making rational decisions, but the episodic nature of their illnesses means that their decision-making capacity will sometimes be impaired. As one scholar explained, “acute episodes of mental illness are ... frequently characterized by a loss of competent decision-making ability.” Thus, when an episode occurs, individuals with mental illnesses may no longer be able to make well-reasoned decisions about their treatment. Indeed, the legal system recognizes that an individual’s decision-making capacity can vary over time, particularly for those who suffer from “alternating periods of competence and incompetence” due to mental illness. Advance directives offer one solution to this problem and a mechanism for averting the “devastating losses” of the type Jane experienced. With an advance directive, Jane’s “rational self” can choose to obtain prompt intervention and override the refusals of her “mentally ill self.”

However, some critics of advance directives argue that they represent a form of paternalism by privileging an individual’s decisions at one point in time over her later decisions. In other words, the “present self” is permitted to “waive rights that the ‘future self’ would otherwise possess.” Accordingly, these critics maintain that the reasoning behind Ulysses directives does not

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12. See Gallagher, supra note 8, at 780.
15. Id. at 746. In a number of states, psychiatric advance directive statutes supply a definition of incompetence or incapacity and a method for determining whether an individual satisfies the criteria. See infra Part III.B.1.
16. Gallagher, supra note 8, at 780 (describing the “devastating losses that frequently accompany the declining judgment and uncontrolled impulsivity characteristic of the early stages of [mania].”).
17. Dresser, supra note 11, at 819.
withstand scrutiny. Yet, advance directives often promote an individual’s rational treatment choices. If Jane could not execute a Ulysses directive and the symptoms of her illness returned, she would be unable to obtain the help she prospectively wanted when she was well. As a result, she would likely re-experience the same kinds of losses that she actively sought to prevent. While advance directives limit the choices of an individual’s “mentally ill self,” they carry out the wishes of her “rational self.” A person’s reasoned decision to commit herself to treatment, and thereby avoid the potentially devastating consequences of her illness, should be respected.

C. Greater Self-Responsibility

Executing an advance directive provides therapeutic benefits and promotes self-responsibility. One scholar identified numerous benefits of advance directives, including: (1) helping individuals with mental illnesses identify and implement preventative measures, (2) persuading them to seek out early treatment, (3) avoiding recurrence by encouraging individuals to take responsibility for treatment decisions, (4) assisting them in setting goals and working toward achieving them, (5) assuring individuals that their choices will be respected to ease worry and stress, and (6) increasing collaboration between mental health consumers and providers. These benefits relate to the larger themes of patient empowerment and self-responsibility. Advance directives allow individuals to “retain the maximum degree of control possible over their lives and over their medical care, even in the face of the most severe and disabling episodes of illness.” By executing advance directives, individuals with mental illnesses assert control over their lives and take responsibility for their futures.

Nevertheless, some critics argue that psychiatric advance directives enable coercion of individuals with mental illnesses by various actors, including healthcare providers, proxy decision-makers, and

18. See, e.g., id. at 787-92. See also Miller, supra note 7, at 730-32 (discussing different views about patient decision-making).
19. Winick, supra note 13, at 81.
the state. Rather than encouraging individuals with mental illnesses to make their own decisions, advance directives could be used to force them to submit to treatments that they do not want. However, the potential for abuse does not justify a categorical rejection of psychiatric advance directives. Instead, states should strengthen the protections afforded to individuals who execute directives.

For example, Washington’s statute includes several provisions to prevent coercion. First, the legislature authorizes an individual with an advance directive to “bring an action to contest the validity of his or her directive.” Therefore, if the directive were executed under coercive conditions, the individual could free herself from its control. Similarly, the statute provides that any person who has reason to believe that “a directive has been created or revoked under circumstances amounting to fraud, duress, or undue influence” may petition the court to have the improper actions reviewed. Second, the statute requires capacity to be reevaluated at regular intervals: if an individual is admitted to inpatient treatment pursuant to the provisions of her directive, then the hospital must reassess the individual’s capacity within seventy-two hours and whenever there is a change in the individual’s condition. This safeguard ensures that individuals will not be subjected to “coercive” treatment for longer than they intended when executing their directives. Third, the statute prohibits treatment facilities and insurance companies from requiring that a directive be executed as a condition for receiving services. As these provisions demonstrate, a number of methods exist to discourage abuse and coercion. Thus, individuals with mental illnesses can execute advance directives and still retain control over their treatment.

D. Stakeholder Support

Many stakeholders, who are intimately familiar with the effects and treatment of mental illness, support advance directives. In Washington, individuals with mental illnesses, particularly those

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22. See, e.g., Dresser, supra note 11, at 781–86.
25. Id. § 71.32.200.
26. Id. §§ 71.32.130(2)(a)(i)–(iii).
27. Id. § 71.32.220.
with chronic and episodic illnesses like Jane’s, pushed for legislation authorizing psychiatric advance directives. Additionally, service providers generally support psychiatric advance directives. In a survey of mental health service providers in two Washington counties, over seventy-five percent of respondents “reported that [psychiatric advance directives] would be useful for consumers and treatment providers.” Considering the potential recognized by the stakeholders in the mental health community—as well as the possibility of promoting more effective treatment, better decision-making, and increased self-responsibility—psychiatric advance directives are unmistakably valuable.

II. THE LEGAL FRAMEWORK SUPPORTING THE VALIDITY OF PSYCHIATRIC ADVANCE DIRECTIVES

A. State Statutes

As a threshold matter, in order for psychiatric advance directives to work in practice, the legal framework must support their use. First, state legislatures must pass statutes that permit individuals to execute advance directives. A majority of states have passed legislation enabling advance directives for medical decision-making, but advance directives in the mental health context have received “relatively little attention” until recently. Between 1991 and 2006, twenty-seven states enacted statutes authorizing psychiatric advance directives in some form. These statutes will be examined later in this Note.

30. Id.
31. Cuca, supra note 10, at 1153.
32. Gallagher, supra note 8, at 746.
In addition to legislation, courts must be willing to enforce psychiatric advance directives. Research has revealed no federal case that directly addresses the enforceability of psychiatric advance directives, so the legal framework is still unsettled. However, the United States Supreme Court has implied that courts should consider advance directives when making decisions about medical care. In *Cruzan v. Director, Missouri Department of Health*, the family of Nancy Cruzan, who was in a persistent vegetative state, sought to withdraw life-sustaining medical treatment based on an earlier conversation Ms. Cruzan had had with a friend in which she had indicated that she would not want to live that way. The Court held that Missouri could require "clear and convincing evidence" of Ms. Cruzan’s wishes.

Although no advance directive was at issue in the case, the Court discussed two relevant issues. First, the Court intimated that patients, even incompetent patients like Ms. Cruzan, have a right to

See Gallager, *supra* note 8, at 769.


36. *Id.* at 282.
control their own medical treatment. In fact, even though the case focused on medical treatment rather than mental health treatment, the Court cited several of its precedents that recognized the right of individuals with mental illnesses to reject unwanted treatment. Second, the Court noted that written instructions—such as those provided in an advance directive—are persuasive evidence of an individual's "prior expressed wishes" regarding medical treatment. This dicta suggests that an advance directive is evidence of an incompetent person's wishes, which, in turn, should be taken into account when a court decides what treatment should be provided. Therefore, Cruzan has been viewed by some legal scholars as implicitly establishing the "right to engage in advance planning for incapacity."

C. State Caselaw

Although the Supreme Court has not directly addressed the right of an individual with a mental illness to engage in advance planning, state courts have recognized such a right. In the New York case of In re Rosa M., a patient with a severe mental illness had revoked in writing her consent to electroconvulsive therapy, stating: "I am withdrawing my consent to electroconvulsive therapy and am refusing any more treatments with this procedure." The court held that the hospital where the patient was involuntarily committed could not administer the treatment over her written objection. The court explained: "The fundamental right of individuals to have final say in respect to decisions regarding their medical treatment extends equally to mentally ill persons." Therefore, even involuntarily committed individuals have the right to control their treatment through advance planning and written instructions.

37. Id. at 286 ("[W]e do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself."). See also Gallagher, supra note 8, at 769 (stating that "the Supreme Court's holding in Cruzan recognized the constitutionally derived right of an incompetent patient to control the course of his or her medical treatment.").
39. Cruzan, 497 U.S. at 284; Gallagher, supra note 8, at 770.
40. Gallagher, supra note 8, at 770.
42. Id.
43. Id. at 545.
44. Id. (citing Rivers v. Katz, 67 N.Y.2d 485, 493 (1986)).
Similarly, in the case of *In re Ingram*, the Washington Supreme Court declined to authorize surgery on a legally incompetent patient over her objections by applying the "substituted judgment" standard. This standard requires the court to "ascertain the incompetent person's actual interests and preferences" and make its ruling based on "the decision . . . which would be made by the incompetent person, if that person were competent." Furthermore, the court said, a legally incompetent person retains her "right to choose or refuse treatment." Thus, an incompetent person's wishes regarding treatment must be taken into account. These cases' analyses make the conclusions drawn from *Cruzan* explicit: individuals deemed mentally incompetent have the right to control their treatment by expressing their preferences in advance. Because written instructions provide strong evidence of an individual's wishes, an advance directive would be very useful for a court that is applying the substituted judgment standard. It follows from these decisions that courts would recognize the validity of psychiatric advance directives under the right circumstances.

### D. Essential Elements of Psychiatric Advance Directive Statutes

The challenge for state legislatures and courts is how to avoid treating individuals with mental illnesses prejudicially while still recognizing the unique problems that their illnesses raise. For example, statutes must account for the fact that individuals with mental illnesses experience alternating periods of competence and incompetence. Therefore, statutes should supply a method for determining competency so that an advance directive becomes active if and only if the person is unable to make decisions. In addition, to discourage bias against individuals with mental illnesses, mental health service providers should be required to comply with psychiatric advance directives and should be permitted to override them only in narrowly defined circumstances. To encourage provider compliance with advance directives, statutes also should grant immunity for following the documents' instructions.

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46. *Id.* at 1372.
47. *Id.* at 1370 (citing Superintendent of Belchertown State Sch. v. Saikewicz, 373 Mass. 728, 752–53 (1977)).
48. *Id.* at 1368.
Furthermore, statutes must address the distinction between refusal of treatment and election of treatment because, as Jane's story illustrates, an individual's mental illness may cause her to reject treatment when it is most needed. First, advance directive statutes must permit individuals to consent in advance to intrusive treatments like hospitalization and medication so that individuals can choose to receive these types of treatment. Second, statutes should enable individuals to waive their constitutional right to refuse treatment, and they should prescribe a procedure for overriding refusals. In this way, individuals like Jane will be able to obtain treatment even when their symptoms cause them to deny their need for it. Third, statutes need to give individuals the option of making their advance directives irrevocable so that the directives will remain in effect as long as they are incapable of making decisions.

The next sections will examine how states have met these challenges in their advance directive laws, and how they might better account for the complexities of chronic and episodic mental illnesses. Washington State, in particular, effectively addresses many of these issues and provides an excellent model for states that wish to revise or adopt psychiatric advance directive statutes.

III. THE THORNY ISSUE OF COMPETENCY IN THE MENTAL HEALTH CONTEXT

A number of challenges may hinder the enforcement of psychiatric advance directives, and these challenges must be addressed when fashioning effective statutes. A unique problem for psychiatric advance directives is the shifting nature of cognitive functioning when an individual has a mental illness. Protections must be in place to ensure that a competent person is not denied the ability to make decisions. Conversely, there must be a method of determining when an individual is incompetent to make decisions so that the directive will take effect. This distinction is particularly important for directives that elect treatment because a person experiencing an acute episode of bipolar disorder, for example, may not recognize the need for treatment while the episode is occurring. Therefore, an accurate and expeditious competency

50. See, e.g., Winick, supra note 13, at 70.
51. Miller, supra note 7, at 745.
52. Cuca, supra note 10, at 1164.
53. Id. at 1162 (explaining that a person's refusal of treatment can sometimes be attributed entirely to symptoms of her mental illness).
determination is required at three stages: (1) when the directive is executed, to ensure that it actually reflects the individual's wishes; (2) when the directive is activated and treatment is administered, to ensure that the individual's contemporaneously expressed wishes should be overridden; and (3) when the individual attempts to revoke the directive, to ensure that the decision is not motivated by symptoms of the illness.

A. Execution

Most states employ a statutory presumption in favor of competence for the execution of advance directives, even for individuals who are committed to psychiatric hospitals. This approach is sensible because individuals with mental illnesses "often have a significant capacity for normal and rational thought and behavior." Much like Jane, who leads a "normal" life most of the time, many individuals with mental illnesses are capable of making well-considered decisions about their treatment.

This view, of course, is not universally shared. Policymakers and practitioners sometimes distinguish between the rights of the mentally ill and the non-mentally ill because they assume that mental illness makes all treatment choices irrational. Fortunately, most states have declined to give public credence to such biased thinking. These states do not presume that mental illness renders a person generally incapable of making decisions. Therefore, individuals executing psychiatric advance directives must meet the same standard of competency as individuals executing other advance directives. A different rule would unnecessarily restrict the liberty of individuals to express their wishes simply because they have a mental illness.

Even with the statutory presumption of competence, mental health service providers may still be reluctant to rely on an advance directive if they cannot verify that the document actually reflects

54. Winick, supra note 13, at 68 n.39.
55. Id. at 67.
56. Gallagher, supra note 8, at 776; Bazelon Center, supra note 20, § Consumers and Providers Speak Out, at p. 5 (reporting the views of some providers who believed that mental health consumers were never competent to make decisions about treatment in advance directives).
57. Winick, supra note 13, at 67 n.39 (noting that the statutory presumption of competence extends to involuntarily committed individuals in most states).
58. See Winick, supra note 13, at 67.
the individual's competent wishes. As one solution to this problem, some states require a psychiatric advance directive to be signed by at least one witness, who must attest to the individual's sound mind and the lack of duress or undue influence. Louisiana also requires a written mental status examination by a physician or psychologist that confirms the individual's decision-making capacity. For the reasons already discussed, this statutory requirement reveals bias against individuals with mental illnesses because they are treated differently on account of their illnesses. Still, considering the reality of provider reluctance, individuals may wish to include a similar attestation by an independent psychiatrist to increase the chances that their directives will be enforced.

B. Activation

1. Selecting the Standard for Activation

A more complicated question is how to determine competency when the advance directive is activated and treatment is actually administered. Three standards could be used in making this determination: (1) legal incompetence (e.g., the standard for guardianship proceedings); (2) decision-making capacity (e.g., the standard for giving informed consent to medical decisions); or (3) dangerousness or severe disability (e.g., the standard for involuntary commitment proceedings). Both legal competency and involuntary commitment standards are insufficient for facilitating early treatment. Instead, decision-making capacity should be the standard for determining when psychiatric advance directives become active.

59. Srebnik & Brodoff, supra note 29, at 257.
60. See, e.g., N.J. STAT. ANN. § 26:2H-105 (West 2005) (requiring one witness who cannot be related to the individual by blood or marriage and cannot be the individual's mental health service provider); TENN. CODE ANN. § 33-6-1004(a-b) (2000) (requiring two witnesses who cannot be affiliated with the individual's mental health service provider).
62. Srebnik & Brodoff, supra note 29, at 257.
63. See, e.g., WASH. REV. CODE § 11.88.010 (2006) (granting courts, and only courts, the power to appoint guardians for persons who have a "significant risk of personal harm" or "financial harm" because of an inability to provide for their needs or manage their finances).
64. See David R. Patterson et al., When Life Support Is Questioned Early in the Care of Patients with Cervical-Level Quadriplegia, 328 NEW ENG. J. MED. 506 (1993).
65. See, e.g., WASH. REV. CODE § 71.05.150(1)(b) (2006) (authorizing involuntary commitment when a court finds that an individual presents "a likelihood of serious harm" or is "gravely disabled").
First, it is important to distinguish between legal incompetence and the incapacity to make treatment decisions because they do not always overlap. Although both standards define a person's cognitive functioning, legal competence must usually be determined by a court, whereas capacity determinations are made by medical professionals. The distinction is crucial because many individuals with mental illnesses are legally competent when in crisis (i.e., a court has not yet ruled to the contrary), but they may be indecisive, ambivalent, or "unable or unwilling to make reasoned decisions about their care." This twilight of decision-making capacity has been termed "quasi-competence." If a court determination is necessary to activate a psychiatric advance directive, many individuals will not be able to obtain the treatment that they want and need to prevent a severe deterioration in their cognitive faculties.

In Washington, a similar story inspired a senator to sponsor the psychiatric advance directive legislation. A man with schizophrenia would periodically stop taking his medication and end up on the streets, threatening people and sometimes landing in jail or an emergency room. His family wanted a way to "break this cycle" and obtain earlier treatment for him, when the symptoms first presented themselves. The desire to receive earlier treatment is a motivating force for some individuals, like Jane, who execute advance directives, and this objective cannot always be achieved by a court proceeding.

Like legal incompetence, the standard for involuntary commitment is inadequate for facilitating early treatment. Families frequently are frustrated by the high thresholds for involuntary commitment. In the absence of an advance directive, involuntary commitment is the primary means of treating individuals with mental illnesses when they refuse treatment. In Washington, for example, a person must be "gravely disabled" or pose a "likelihood of serious harm" to herself or others before she can be treated

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67. La Fond & Srebnik, supra note 2, at 539.
68. Id.
69. See infra Part III.B.2.
70. Anderson, supra note 28, at 803.
71. Id.
72. Id.
73. See infra Part III.B.2 for a discussion of the barriers presented by court proceedings.
74. Anderson, supra note 28, at 800–01.
against her will. As one individual with a mental illness testified, "When someone is allowed to ‘decompose’ so severely before they can get help under the Involuntary Treatment Act, they never come back quite the same." Similar to Jane’s experience, an individual with a mental illness can be legally competent and not dangerous, while still being unable to make rational decisions during episodes of her illness. Therefore, a different procedure is needed for individuals who desire early treatment but whose illnesses may prevent them from recognizing it at the time.

Some state legislatures have implicitly acknowledged the need to distinguish between commitment standards and capacity to make healthcare decisions. For example, Hawaii’s statute provides that the directive becomes effective when the individual lacks capacity, which is defined as the “ability to understand the significant benefits, risks, and alternatives to proposed mental health care or treatment and to make and communicate a mental health care decision.” Similarly, psychiatric advance directives become operable in several other states when the individual is “incapable,” which means that the “ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions.” Thus, for the advance directive to be activated, the individual need not be dangerous to herself or others, as is frequently required for involuntary commitment. Instead, she must have an impaired ability to understand information and make decisions, which is a definition that “quasi-competent” individuals will more readily satisfy.

On the other hand, a lower standard for activating psychiatric advance directives increases the possibility that individuals will have their decision-making authority taken away prematurely. The

75. In re Guardianship of Anderson, 564 P.2d 1190, 1192 (Wash. Ct. App. 1977) (citing WASH. REV. CODE § 71.05.150(1)(b) (2006)). The Washington legislature defines “gravely disabled” as an individual suffering from a mental disorder who either “[i]s in danger of serious physical harm resulting from a failure to provide for his or her essential human needs” or “manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions.” WASH. REV. CODE § 71.05.020(16). A “likelihood of serious harm” to self or others includes physical harm only (e.g., threats or attempts to commit suicide, threats or acts of violence). Id. § 71.05.020(19).

76. Anderson, supra note 28, at 801 (recounting testimony as paraphrased by a legislative assistant).


79. La Fond & Srebnik, supra note 2, at 539.
"one-size-fits-all" standards for incapacity also do not account for
the unique ways in which mental illness manifests itself among
individuals. In response to these concerns, some states have provided
flexibility for individuals to determine their own standards of inca-
pacity.89 In Washington and Pennsylvania, for example, the
individual may designate when the directive becomes effective.81
Hence, the individual could specify any circumstances that consti-
tute early warning signs for her experience of the illness. For
instance, Jane might specify that she wants her directive to be acti-
vated when she stops sleeping or when she accumulates a certain
amount of debt, since those are symptoms she experienced be-
fore.82 Or she could decide that she wants to be admitted for
treatment upon the recommendation of her personal psychiatrist
or a close family member, since they would be able to recognize
deviations from her typical behavior.83 Individuals with episodic
illnesses, such as bipolar disorder, have the advantage of past ex-
perience to inform their decisions about when their directives
should become active.84

A flexible activation standard enables individuals with mental
illnesses to retain more control over their treatment and recog-
nizes that they are generally capable of making their own
decisions.85 The New York Court of Appeals confirmed the right of
individuals with mental illnesses to retain that type of control:
"This right [of self-determination] extends equally to mentally ill
persons who are not to be treated as persons of lesser status or dig-
nity because of their illness."86 In sum, the flexible activation
standards developed by some states allow individuals to tailor their
advance directives more specifically to their needs, and that

80. Id.
81. 20 PA. STAT. ANN. § 5824(a)(2) (West 2005); WASH. REV. CODE § 71.32.060(3)
(2003).
82. See Gallagher, supra note 8, at 752; La Fond & Srebnik, supra note 2, at 540.
83. See Gallagher, supra note 8, at 752; La Fond & Srebnik, supra note 2, at 540.
84. Srebnik & Brodoff, supra note 29, at 257. The benefit of past experience is one
significant difference between psychiatric advance directives and directives dealing with end-
of-life issues. Individuals with mental illness have experienced episodes in the past, so they
can identify the warning signs and they know which treatments work for them. On the other
hand, major medical crises happen rarely in an individual's lifetime, so it is nearly impossi-
ble to articulate specific, accurate choices about what one would want in hypothetical
situations. See Angela Fagerlin & Carl E. Schneider, Enough: The Failure of the Living Will,
85. See Gallagher, supra note 8, at 777 ("The courts have made clear that neither the
fact of psychiatric illness itself, nor the fact of commitment for psychiatric treatment, is tan-
tamount to a determination of incompetence to make treatment decisions.").
86. Rivers v. Katz, 495 N.E.2d 337, 341 (N.Y. 1986) (holding that involuntarily commit-
ted patients have the right to refuse antipsychotic medication).
flexibility promotes equal treatment for individuals with mental illnesses.

2. Method of Determining Competency

State statutes also should specify who determines competency and how. One traditional method of determining competency is the three-part Beck test, which is typically administered by a court when an individual is refusing treatment. The court must answer three questions: (1) Is the individual aware that she has a mental illness? (2) Does she have sufficient knowledge about the illness and its treatments? (3) Is she free of delusional beliefs in making her decision to refuse treatment? If the answer to any of these questions is “no,” then the individual is deemed incompetent to make decisions about treatment. Although there is nothing empirically limiting about the test itself, administration of the assessment as part of a court proceeding may diminish the effectiveness of advance directives. First, court proceedings delay decision-making and are insufficient for individuals who need immediate treatment. Second, the public nature of court proceedings can cause social consequences and psychological damage. One response to these concerns would be accelerated court proceedings to determine competency, which would require changes in the judicial system that might be difficult to implement.

Another alternative would be capacity determinations by healthcare providers using the Beck criteria or other proven assessments, which could be authorized by statute or written directly into an individual’s advance directive. Psychiatric advance directive statutes often permit the capacity determination to be made by healthcare providers instead of requiring a formal competency assessment by the courts. For instance, in a number of states, the determination may be made by two providers. At least one state allows the de-
termination to be made by a single provider. This alternative represents one of the benefits of psychiatric advance directives: the “ability to effectuate the patient’s intent without the delay, expense, and humiliation of going to court.” Accordingly, many states agree about who should determine capacity: healthcare providers.

How providers should make the determinations, however, is more difficult to answer because there is no “gold standard” instrument for assessing decision-making capacity. As a first step, Professors Paul S. Appelbaum and Thomas Grisso at the University of Massachusetts Medical School have developed an instrument that assesses decision-making capacity. The structured interview evaluates the individual’s ability to: communicate treatment choices, understand relevant information, appreciate the nature of the situation and likely consequences, and weigh potential risks and benefits of decisions. New Mexico offers similar guidance in its statute. The statute requires a written certification of incapacity by two providers that details the individual’s ability to understand the nature, consequences, benefits, and risks of proposed treatments and her ability to communicate a choice about treatment. The statute even includes a sample certification form. Both the Appelbaum/Grisso instrument and the New Mexico statute provide useful models for capacity determinations that can be administered by healthcare providers.

In sum, to facilitate early treatment, state statutes ideally should consider two issues when defining the activation point for psychiatric advance directives. First, individuals should have the flexibility to specify the circumstances under which their directives become active. Second, healthcare providers should be permitted to evaluate decision-making capacity, using assessments developed for that purpose.

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Rem. Code Ann. § 137.001(6) (Vernon 1997) (stating that a determination of incapacity can only be made by a court in a guardianship proceeding or a medication hearing).
96. Gallagher, supra note 8, at 779.
97. Srebnik & Brodoff, supra note 29, at 257.
100. N.M. Stat. § 24-7B-5(F-G) (West 2006).
101. Id. § 24-7B-5(G).
C. Revocation

The third stage, revocation, is particularly important for individuals who execute advance directives with the goal of overriding illness-induced refusals of treatment. If the individual could revoke the directive at any time, then she would be able to do so during an acute episode, when she most needs the treatment. For example, in Jane’s situation, the manic episode impaired her judgment and she acted out in self-destructive ways, but the illness prevented her from recognizing the problems with her behavior. Because she refused to accept treatment and did not meet the involuntary commitment standards in her state, she was allowed to continue on her devastating path. After recovering from the episode, she executed a directive with the express intent of averting similar situations in the future. Jane sought prospectively to bind herself to treatment in preparation for future episodes because she knew that the illness would likely cause her to refuse treatment again. Yet, if she were allowed to revoke the directive at any time, she could revoke it during a manic episode and her intent would not be effectuated.

States have approached the issue of revocation from three directions, which might be called “restrictive,” “liberal,” and “flexible.” States favoring the restrictive approach require a capacity determination before allowing an individual to revoke a psychiatric advance directive. In these states, when an individual wants to revoke her directive, her competency would be assessed in a manner similar to that used at activation. Many states require that individuals be “capable” or “competent,” as determined by healthcare providers or a court, before permitting revocation.

At least one state prefers the liberal approach, allowing revocation at any time regardless of the individual’s mental state. Kentucky permits a psychiatric advance directive to be revoked when any of the following actions are taken: the individual signs and dates a document expressing her intent to revoke; the individual’s mental health professional states that the individual has sufficient mental capacity; or the individual’s condition is substantially the same as the Idaho Code.

102. Srebnik & Brodoff, supra note 29, at 261; see also Miller, supra note 7, at 745.

ual makes an oral statement to the same effect; or the individual destroys her directive. 104 These liberal revocation options provide insufficient protection for individuals like Jane. Although Kentucky is arguably attempting to promote patient self-determination by allowing individuals to change their minds easily, the liberal approach harms those individuals who would choose irrevocability as a means to prevent severe deterioration in their conditions.

The flexible middle ground is the best option because it allows the individual to decide how revocation will be accomplished. Several states have selected this approach. In Arizona, revocation is permitted at any time “[u]nless limited by the express authority in the document.” 105 In New Jersey, the individual may choose to make the directive irrevocable, but revocability is presumed if the individual does not express a preference. 106 Thus, revocation at any time is the default rule, but the Arizona and New Jersey legislatures explicitly permit individuals to change the default rule by including different instructions in their directives. Washington has selected the opposite default rule: an individual may revoke the directive only when she has capacity, unless the individual elected at the time of creating the document to enable revocation while incapacitated. 107

Either default rule is adequate as long as the rule is clearly communicated to individuals who execute psychiatric advance directives. Most importantly, the flexibility provided by these statutes allows individuals like Jane, who wish to protect themselves from the effects of their illnesses, to choose irrevocability. At the same time, the statutes permit other individuals, who wish to keep their options open, to choose revocability. In some cases, the individual may want to specify additional criteria that must be satisfied before allowing revocation, such as requiring the approval of her decision-making agent or personal psychiatrist. In those cases, a formulation like Arizona’s would be preferable because it grants the individual broad authority to craft a tailored solution for her unique needs.

In conclusion, competency is a challenging issue for individuals with mental illnesses because their decision-making ability varies over time. Advance directives are a valuable tool to help individuals

104. KY. REV. STAT. ANN. § 202A.428 (LexisNexis 2003). Most states that have only general durable power of attorney statutes also allow revocation at any time. Gallagher, supra note 8, at 778.
105. ARIZ. REV. STAT. § 36-3285 (LexisNexis 1999).
manage their illnesses, but they must be used carefully. For individuals like Jane, advance directives need to become active when their decision-making is compromised, and remain effective until their cognitive faculties are restored. Because each individual's needs and preferences are unique, state statutes should allow individuals to decide when their directives are activated and when they can be revoked. Washington's flexible scheme enables individuals like Jane to receive early treatment and preempt the devastating consequences of their illnesses.

IV. THE CHALLENGE PRESENTED BY THE RIGHT TO REFUSE TREATMENT

A. Federal Caselaw

1. The Right to Refuse Treatment

In addition to competency issues, constitutional rights may also complicate an individual's ability to override illness-induced refusals of treatment through an advance directive. The Supreme Court has established a constitutionally protected right to refuse medical treatment. The Court has held in several cases that individuals have a significant liberty interest in avoiding unwanted mental health medication and hospitalization. In Vitek v. Jones, the Court held that the involuntary transfer of a prisoner to a mental hospital "implicate[d] a liberty interest that is protected by the Due Process Clause." The Court directed that certain procedures must be followed for involuntary hospitalization, including notice and a hearing.

In Washington v. Harper, a prisoner housed in the mental health unit challenged the prison's policy of administering psychiatric medication over prisoners' objections when they were "gravely

108. Cruzan v. Dir., Mo. Dep't of Mental Health, 497 U.S. 261, 279 (1990). Although Cruzan only assumed the existence of the right to refuse life-sustaining medical treatment, the later case of Washington v. Glucksberg went further, declaring that the Court in Cruzan found that the right to refuse treatment deserved special protection under the Fourteenth Amendment. Washington v. Glucksberg, 521 U.S. 702, 721–22 n.17 (1997).


111. Id. at 487–88.

112. Id. at 495–96.

disabled" or posed a "likelihood of serious harm." The Court recognized that the prisoner "possesse[d] a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment." However, the Court also held that the right was qualified by important state interests. Moreover, the Court declared that forced medication in the prison environment satisfies due process requirements as long as "the inmate is dangerous to himself or others and the treatment is in the inmate’s medical interest." These cases establish the right to refuse unwanted mental health treatment, but they also clarify that the right is limited by the state’s police power, which is particularly strong in the prison context.

Although the Supreme Court does not appear to have addressed this exact issue outside the prison context, two Courts of Appeals have acknowledged that patients in psychiatric hospitals also have a qualified constitutional right to refuse psychiatric medication. In Rogers v. Okin, a group of psychiatric patients brought suit against a hospital for its forcible medication of patients. The First Circuit held that state law created a constitutionally protected liberty interest in avoiding forcible medication. Citing Vitek, the court announced that certain procedures were required to override the individual’s right to refuse medication. In Rennie v. Klein, the Third Circuit noted that an involuntarily committed patient had a “constitutional right to refuse antipsychotic drugs.” But that right is not absolute: if the patient posed a danger to himself or others (the standard under state law) and his healthcare providers determined that medication was necessary, then the providers’ judgment was presumptively valid. To overcome that presumption, the patient would have to prove that the decision was a “substantial departure” from accepted medical standards or practice. Therefore, although some protection exists for the right to refuse mental health treatment, this right can be outweighed by

114. Id. at 215.
115. Id. at 222.
116. Id. at 227.
117. Id.
118. Rogers v. Okin, 738 F.2d 1 (1st Cir. 1984).
119. Id. at 2.
120. Id. at 6.
121. Id. at 7–9.
122. Rennie v. Klein, 720 F.2d 266 (3rd Cir. 1983).
123. Id. at 269.
124. Id. (quoting Youngberg v. Romeo, 457 U.S. 507, 323 (1982)).
125. Id.
important state interests, such as securing the safety of patients and third parties.

2. No Right to Obtain Treatment

The right to obtain treatment, on the other hand, is not constitutionally protected in the same manner. The courts do not recognize a constitutional right to psychiatric hospitalization. In *Wilson v. Formigoni*, the Seventh Circuit held that there was "no constitutional right... to be involuntarily committed in a mental health facility." In addition to judicial pronouncements on this issue, a number of practical obstacles may prevent individuals from obtaining treatment that they request in their directives, including: limited financial resources; treatment methods banned by professional ethics; medication unapproved by the FDA; restrictions in insurance policies or government benefit programs; the liberty interests of healthcare providers, who cannot be forced to provide treatment with which they disagree or that is contrary to accepted medical practice; and public policy considerations. In sum, even if an individual elects to receive treatment in a psychiatric advance directive, there is no guarantee that she will be able to obtain it.

B. State Statutory Solutions

The combination of these two propositions—the right to refuse treatment and the absence of a right to obtain treatment—raises a troubling possibility for individuals like Jane who wish to protect their future interests by executing advance directives. Despite their specific instructions to the contrary, these individuals may not be able to receive treatment if their illnesses cause them to refuse it at critical times. An individual's "present unwillingness" to accept treatment implicates the right to refuse treatment and defeats the "previously given consent" in her advance directive. Fortunately, state law can resolve this dilemma. Because the election of treatment is not subject to the same constitutional protections as the

126. Winick, supra note 13, at 70; Gallagher, supra note 8, at 773.
127. Wilson v. Formigoni, 42 F.3d 1060 (7th Cir. 1994).
128. Id. at 1066.
129. Gallagher, supra note 8, at 773; Winick, supra note 13, at 70.
130. Anderson, supra note 28, at 796.
refusal of treatment, states have greater latitude to craft solutions for treatment-election scenarios.\textsuperscript{131}

1. Advance Consent to Intrusive Treatments

To be effective for individuals like Jane, psychiatric advance directive statutes must enable individuals to consent to mental health treatment in advance—particularly intrusive treatments. For example, antipsychotic medications are considered intrusive because of their side effects.\textsuperscript{132} Nevertheless, many mental illnesses can be stabilized by medications, so individuals should be allowed to choose that type of treatment. But not all states agree with this proposition. In Kentucky's psychiatric advance directive statute, individuals are limited to including "one or more of the following" in their directives: refusal of specific medications or electric shock therapy and "stated preferences" for medications or emergency interventions.\textsuperscript{133} An individual's request to receive treatment appears to be less enforceable because the term "preferences" suggests that complying with the individual's instructions is optional, while "refusal" is a clear restriction. Yet, providing treatment is often consistent with the individual's best interest, so psychiatric advance directives that request treatment should not be relegated to a lower status.\textsuperscript{134}

Many statutes specify that psychiatric advance directives "may include consent to or refusal of mental health treatment."\textsuperscript{135} However, only a few statutes explicitly authorize individuals to consent to intrusive treatments in their directives. For example, North Carolina's statute authorizes individuals to "grant or withhold authority for mental health treatment, including, but not limited to, the use of psychotropic medication, electroconvulsive treatment, and admission to and retention in a facility for the care or treatment of mental illness."\textsuperscript{136} In states that specifically define

\begin{itemize}
\item\textsuperscript{131} Winick, supra note 13, at 71.
\item\textsuperscript{132} Gallagher, supra note 8, at 761.
\item\textsuperscript{134} Gallagher, supra note 8, at 782.
\item\textsuperscript{136} N.C. Gen. Stat. § 122C-73(c1) (1997). See also Ind. Code § 16-36-1.7-3 (2004) (enabling an individual to consent to hospital admission, medication, seclusion, restraint, electroconvulsive therapy); Minn. Stat. § 253B.03(6)(d) (1991) (allowing a proxy decision-maker to "make decisions about intrusive mental health treatment").
\end{itemize}
treatment in a similar manner, individuals can consent in advance to hospitalization and medication.

But authorization to consent to treatment in advance still provides inadequate protection for individuals, like Jane, whose illnesses cause them to refuse treatment during acute episodes. Unless state law explicitly allows it, healthcare providers may be hesitant to hospitalize individuals over their objections, even if an advance directive consents to that type of treatment. The Washington statute solves this problem by establishing a procedure for these individuals to consent to treatment in advance and for providers to override illness-induced refusals. The provision only applies under certain conditions. First, the individual must have chosen for the directive to be irrevocable during incapacity. Second, she must have consented to inpatient mental health treatment in the directive. Third, she must be refusing treatment at the time of admission. Where these conditions are met, the individual may be admitted if a provider takes the following actions: (1) evaluates her mental condition and determines that she is incapacitated, (2) obtains the informed consent of the agent (if any), (3) makes a written determination that she needs treatment that cannot be given in a “less restrictive setting,” and (4) documents these findings in the medical chart. These procedures enable individuals like Jane to obtain treatment even when they refuse to cooperate, which may be the precise reason why they executed advance directives in the first place.

In sum, to be effective for individuals who wish to elect treatment in advance, state statutes should enable them to consent to intrusive treatments in their directives. Furthermore, to be most effective for individuals like Jane, states should follow Washington’s example and specify a procedure to override illness-induced refusals.

2. Waiver of the Right to Refuse

Consenting to treatment and surrendering the right to refuse treatment implicate different rights. Thus, in addition to provid-

137. Srebnik & Brodoff, supra note 29, at 261.
139. Id. § 71.32.140(1)(a).
140. Id. § 71.32.140(1)(b).
141. Id. § 71.32.140(1)(c).
142. Id. § 71.32.140(2).
ing consent, the individual must clearly waive the right to refuse treatment in her directive. To waive a fundamental right, the Supreme Court requires the waiver to be “knowing, voluntary, and intelligent.” Although the right to refuse mental health treatment has not been declared fundamental, it does receive some protection under the Fourteenth Amendment. Therefore, an explicit waiver may be required.

Research did not reveal any state directly addressing this issue in the language of its psychiatric advance directive statute. However, Washington includes some language in its form directive that might be a first step toward meeting the waiver requirement. The form describes the irrevocability option as follows: “I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I may receive treatment that I specify in this directive, even if I object at the time.” This waiver directly addresses Jane’s dilemma, allowing her to clearly express her intent that the directive’s instructions should override her objections when she is incapacitated.

Of course, the “knowing, voluntary, and intelligent” waiver requires more than just checking a box on a form: Jane must comprehend what she is agreeing to and the consequences of that decision. First, she must know that she has a right to refuse treatment so that she understands what she is giving up. To facilitate that understanding, the form could include an explanation of patient rights. Additionally, the directive would most likely be upheld if she explained her reasons for wanting to waive the right to refuse treatment. For example: “In the past, a manic episode almost ruined my life and I want to stop that from happening again. When I am manic, I do not realize that I need treatment because the illness takes away my ability to make good decisions for myself. I am writing this directive because I want to be able to get treatment while I am manic, even if I am saying that I do not want treatment at the time.” To encourage this type of narrative, the form could ask an open-ended question such as: “Why would you want to receive treatment if you are saying ‘no’ at the time? Is there something about your illness or your history that makes you want to choose this option?” As another alternative, the individual could

144. *Id.* at 796 n.9 (citing Brady v. United States, 397 U.S. 742, 748 (1970)).
145. See *supra* Part IV.A.1.
146. WASH. REV. CODE § 71.32.260 (2003).
147. See Gallagher, *supra* note 8, at 778 (recommending that individuals include reasons for their decisions when executing psychiatric advance directives).
make an audiotaped or videotaped statement that explains her reasons. Washington has taken the first step toward facilitating a waiver of the right to refuse treatment, but further safeguards are needed to ensure that individuals understand their directives and to increase provider compliance.

The constitutional right to refuse treatment presents a potential obstacle for individuals like Jane who want to obtain treatment when their illnesses cause them to refuse it. Other states should follow Washington's lead to help individuals overcome this obstacle. First, statutes should specifically permit individuals to consent to intrusive treatments, such as medication and hospitalization, in their directives. Second, statutes should detail a procedure for healthcare providers to follow when an individual with compromised decision-making ability is refusing treatment that she requested in her directive. Finally, statutes should facilitate an express waiver of the right to refuse treatment for those individuals who choose to have their directives override refusals.

V. ENCOURAGING THE COOPERATION OF MENTAL HEALTH SERVICE PROVIDERS

A. The Duty to Comply and Exceptions

In order for psychiatric advance directives to be enforced in practice, mental health service providers must be willing to follow their instructions. Reports indicate that compliance with medical care directives occurs twenty to fifty percent of the time, though some observers believe that the rates for psychiatric advance directives may be higher. To increase compliance rates, statutes should explicitly instruct providers to follow directives. A number of statutes do include a duty to comply.

Yet, many statutes also establish mechanisms for overriding psychiatric advance directives. Most commonly, states empower providers to override a directive when a court order contradicts the directive or when there is a life-threatening or health-endangering

150. See, e.g., Idaho Code Ann. § 66-605(1) (1998) ("The physician or provider shall act in accordance with an operative declaration when the principal has been found to be incapable."); N.C. Gen. Stat. § 122C-74(g) (1997) (substantially the same as the Idaho Code); 20 Pa. Stat. Ann. § 5804(a)(1) (West 2005) ("An attending physician and mental health care provider shall comply with mental health declarations and powers of attorney.").
Other typical override provisions authorize the provider to act in a manner contrary to the directive if the directive is inconsistent with "reasonable medical practice," if requested treatments are unavailable, or if compliance would violate the law. These overrides are reasonable because providers must consider not only the individual's preferences but their own ethical and legal duties as well.

Nonetheless, a more critical analysis reveals that some override provisions may be driven by prejudice against individuals with mental illnesses, based on the belief that they cannot make rational decisions for themselves. For example, the Michigan statute authorizes durable powers of attorney for both medical care and mental health care. Yet, the override provisions regarding reasonable medical practice, availability of treatments, and compliance with the law only apply to mental health care. If these overrides were motivated solely by concerns about providers' ethical and legal duties, then they should also apply to medical care. In contrast, the Maryland provision that "[e]thically inappropriate treatment [is] not required" applies equally to medical and mental health care. Michigan's choice to expand the overrides in the mental health context signals that the legislature did not completely trust individuals with mental illnesses to make their own decisions and felt compelled to give providers a means of circumventing the wishes of those individuals.

Indiana's statute exemplifies even more blatant paternalism, stating, "This chapter does not preclude an attending physician from treating the patient in a manner that is [in] the best interest

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153. Several arguments have been made against these override provisions. For example, the Bazelon Center criticizes the "availability" override because of its ambiguity: "Conceivably, the phrase could refer to economic or geographic availability or inadequate numbers of trained staff." Bazelon Center, supra note 20, § Analysis of State Laws, at p. 5. As for the "reasonable medical practice" override, "objections . . . have been raised because [it] subordinate[s] consumer preferences set forth in [psychiatric advance directives] to routine practice." Srebnik & Brodoff, supra note 29, at 258. Providing definitions of the terminology in the statutes might resolve some of these concerns.
155. Id. § 700.5511(4) (1998).
156. Md. Code Ann., Health-Gen. § 5-611 (LexisNexis 1993) (stating that the provision applies to "this subtitle," which includes advance directives for mental health services in Section 5-602.1 and advance directives for health care generally in Section 5-602).
of the patient or another individual." This override provision allows providers to disregard psychiatric advance directives whenever they disagree about the most effective treatment. As a result, the directives become practically unenforceable. In light of new federal caselaw, states should be careful about unequal treatment of individuals with mental illnesses in their advance directive statutes. In *Hargrave v. Vermont,* the Second Circuit condemned the same type of prejudice that likely animated the Michigan and Indiana override provisions. The court held that an override provision in Vermont’s durable power of attorney statute that applied only to mentally ill individuals constituted discrimination.

Several states have developed more respectful methods for handling situations in which providers disagree with directives. The Louisiana statute allows a directive to be overridden in emergencies or when “the treating physician determines that psychotropic medication is essential.” Although the latter exception might seem similar to those discussed above, it is, in fact, quite different because the statute delineates extensive procedures to be followed before override is permitted. As an initial matter, the director of the facility must conduct an administrative review, which provides the individual with notice and a hearing. In addition, the statute identifies the criteria on which the override decision must be based, including: (1) the degree of danger posed by the individual to herself or others, (2) whether the treatment is “the least restrictive alternative” and the “most medically appropriate,” and (3) a balancing of the risks and benefits. All of these requirements seek to protect the individual’s rights, and they ensure that healthcare providers will only override her wishes when it is absolutely necessary.

As a second example, Pennsylvania and Tennessee have developed a different solution to the problem of provider disagreement with directives. The Pennsylvania statute requires a provider who “cannot in good conscience comply with a declaration” to “make every reasonable effort to assist in the transfer of the declarant or principal to another physician or mental health care provider who will comply.” Tennessee’s statute contains a similar provision that

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159. *Id.* at 37.
161. *Id.*
162. *Id.*
163. *Id.*
directs the provider to "arrange for the prompt and orderly transfer of the patient to the care of others" when the provider is unwilling to carry out the instructions in a directive. This compromise respects the rights of the doctor, who is not forced to provide treatment under protest, while still respecting the rights of the individual, who is given the maximum opportunity to receive her preferred treatment.

After the Hargrave decision, it is discriminatory for advance directive overrides to be more extensive in the mental health context than in the medical context. Some overrides are reasonable, such as those that permit advance directives to be disobeyed in life-threatening emergencies or when the instructions violate the law. Nevertheless, states should be cautious about permitting healthcare providers to override directives when they merely disagree with the instructions. Statutory provisions that establish specific criteria or transfer procedures in such situations offer an attractive compromise between the rights of doctors and the rights of patients.

B. Provider Immunity

In a study by the Bazelon Center for Mental Health Law, many mental health service providers supported the use of advance directives, but they were also concerned about how advance directives would affect their legal and ethical responsibilities. In response to their legal concerns, statutes should grant immunity for providers who make good-faith efforts to comply with directives.

Some statutes do not mention immunity at all, which is clearly insufficient to allay the concerns of providers. Other statutes grant immunity for certain actions but not others. For example, several states protect healthcare providers from civil and criminal liability if they administer or fail to administer treatment in reliance on a

166. The Bazelon Center conducted a three-year study "to explore the legal enforceability of advance directives for psychiatric care and promote their use." Bazelon Center, supra note 20, § Introduction and Summary, at p. 1. As part of the study, the Bazelon Center asked consumers and providers for their opinions about psychiatric advance directives. Id.
167. Id.
168. See Winick, supra note 13, at 71 n.49.
directive that turns out to be invalid. At least one state grants immunity only when a provider fails to treat an individual in accordance with her directive because the provider is unaware of the directive's existence. These narrow grants of immunity are unlikely to reassure providers who are trying to decide whether or not to follow an individual's directive.

Washington appears to offer the most comprehensive protection for providers. The statute grants immunity when providers: (1) act in accordance with a directive that turns out to be invalid, (2) provide treatment without knowledge of the directive, (3) determine that the individual is or is not incapacitated, (4) override the directive for one of the permitted reasons, or (5) provide treatment in accordance with the directive. Other states have included several of these categories in their immunity grants. However, research did not reveal any other state that included all five categories. Surprisingly, the fifth category has not been adopted in many states. Yet, immunizing providers for treating an individual in accordance with her directive may be the most important immunity in the majority of cases to encourage compliance because the instructions in a directive may not correspond with the course of treatment that the provider would recommend. Therefore, providers may need extra assurance that they will not be penalized for promoting patient preferences over their own medical judgments. In sum, states should grant broad immunity for providers, as in Washington, to encourage compliance with psychiatric advance directives.

**CONCLUSION: REFORMING PSYCHIATRIC ADVANCE DIRECTIVE STATUTES TO BENEFIT INDIVIDUALS LIKE JANE**

A legal framework for psychiatric advance directives is growing and evolving. Washington State, in particular, has a well-developed statute that directly addresses the critical issues facing individuals

173. See, e.g., 755 Ill. Comp. Stat. 43/55 (1995) (providing immunity for the determination of capability or incapability to revoke and the administration or failure to administer treatment in reliance upon the agent's decision or the validity of the directive); N.M. Stat. Ann. § 24-7B-11 (West 2006) (providing immunity for complying with a directive, assuming the validity of a directive, and making use of permitted overrides, as well as complying or declining to comply with an agent's decision based on the agent's apparent authority or lack thereof); N.C. Gen. Stat. § 122C-75 (1997) (granting immunity for the determination of capability or incapability, the absence of knowledge of revocation, and the administration or failure to administer treatment in reliance upon the validity of the directive).
like Jane, who wish to bind themselves to treatment in advance and avoid the devastation that often accompanies acute episodes of their illnesses. The process that Washington followed in drafting its statute provides one explanation for its comprehensiveness and sensitivity: the statute was the result of a two-year collaboration between mental health consumers, mental health service providers, attorneys, and legislators.\textsuperscript{174}

Born of multiple perspectives, the Washington statute combines elements that are especially important in treatment-election scenarios. Preeminently, the statute offers flexibility, enabling Jane to define when her directive becomes active and to choose whether her directive will be revocable during incapacity. Thus, each individual can craft a personalized plan for her unique situation. In addition, the statute gives Jane the authority to consent to intrusive mental health treatment, including hospitalization and medications that have worked for her in the past, and authorizes providers to administer the treatment over her objections if certain conditions are met. Also important in Jane's situation is her ability to make the directive truly binding so that she cannot change her mind while in the throes of mania.

By simultaneously providing flexibility and stability, the Washington statute recognizes that individuals with mental illnesses are capable of making their own treatment decisions and offers a mechanism for these individuals to retain control even when they are incapacitated. Other states should consider adopting similar statutory provisions that address the needs of individuals, like Jane, who wish to take responsibility for their illnesses and remain healthy, productive members of society.

\textsuperscript{174} Anderson, \textit{supra} note 28, at 803.