Empower People with Mental Illness through Ulysses Arrangements

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EMPOWERING PEOPLE WITH MENTAL ILLNESS THROUGH ULYSSES ARRANGEMENTS

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Abstract

Acute episodes of mental illness often prevent people from realizing they are sick and cause them to refuse intervention. Once a person refuses treatment, the only way she can obtain care is as an involuntary patient. By the time a person’s behavior meets the strict criteria to warrant involuntary hospitalization, devastation has often already occurred. This Article argues that a person should have the right to enter a Ulysses arrangement, a special type of mental health advance directive, through which a person authorizes a doctor to administer treatment during a future episode even if the episode induces the person to refuse care. The Uniform Law Commissioners enacted the Uniform Health-Care Decisions Act as a model statute to address all types of advance health care planning, including planning for mental illness. However, the Act focuses on end-of-life care and fails to address many issues faced by people with mental illness. Most importantly, the Act prevents people from entering Ulysses arrangements. This Article recommends the Uniform Law Commissioners adopt a model mental health advance directive statute that includes authority to enter a Ulysses arrangement. Appendix A sets forth model statutory provisions.

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"We are going to need to work on making access to mental health care as easy as access to a gun."1 President Barack Obama

INTRODUCTION

Mr. Smith's adult daughter begged police to drive to her father's house and transport him to the hospital. Mr. Smith, diagnosed with bipolar disorder, was in the midst of an acute manic episode. His daughter had received his delusional letters bragging about his upcoming role in a blockbuster film. Every time Mr. Smith became manic, psychosis lead him to a fantasy world in which he starred in a movie filmed by hidden cameras. When manic, he did not realize he was sick and adamantly refused treatment. Police agreed to check on him to determine whether he met the criteria for involuntary emergency detention and admission in a hospital. His daughter was all-too-familiar with the strict criteria. It had destroyed her father's life. Hours later, police informed her that although Mr. Smith acted bizarrely, they could not transport him to the hospital against his will because his behavior did not indicate that he was a danger to himself or others.

A week later, police found Mr. Smith in front of his apartment wearing only underwear, screaming obscenities, and darting into the street. Concerned that a car might hit him, police decided he met the criteria and transported him to the hospital against his will. His daughter felt tremendous relief. Two weeks of inpatient treatment would bring her father back to his gentle self. Seventy-two hours later, as required by law, doctors discharged Mr. Smith against medical advice even though he was still manic. They explained that he demanded discharge and did not meet involuntary placement criteria. Days later, police arrested Mr. Smith who was driving one hundred and twenty miles an hour on a freeway. Psychosis made him believe that he was in a televised drag race. The jail health clinic gave him lithium but failed to monitor his fluid intake. He suffered lithium toxicity. It is now medically unsafe for him to take lithium. He must rely on other treatments.

Before the onset of his illness, Mr. Smith was a mild-mannered accountant. When he takes his medication, he is still that person. Although the highs are intoxicating, when he is not under the spell of an episode, he dreads another mania. Manic episodes have given him a criminal record and cost him his marriage, his relationship with his son, his career, two years of commitment in a state psychiatric hospital, dear friendships, and his savings. Mr. Smith wants to prevent further devastation.

1 Now is the Time, the President's Plan to Protect our Children and our Communities by Reducing Gun Violence 13 (2013), http:whitehouse.gov.
In the wake of the Newtown tragedy, President Obama announced his plan to protect communities from gun violence. A key component of the plan is to improve access to mental health services. Although the vast majority of people with mental illness are not violent, recent mass shootings in Newtown, Tucson, Aurora, and Virginia Tech illustrate how some cases of untreated mental illness develop into crisis situations. Acute episodes of mental illness often prevent people like Mr. Smith from realizing they are sick and need treatment. Once an episode induces a person to refuse care, her only way of obtaining treatment is through involuntary commitment. Allowing a person to decompose to such an extent that he meets involuntary commitment criteria postpones intervention for so long that, often, devastation has already occurred. Delaying intervention risks the safety and health of the person and the public and often results in unwarranted arrests and criminal records, damaged relationships, and financial ruin.

To prevent such devastation, patients should be able to form Ulysses

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2 Id.
3 Id.
4 Id.
5 See KAY REDFIELD JAMISON, AN UNQUIET MIND 36 (Random House, Inc. 1995) (describing mania, "my mind seemed clear, fabulously focused... not only did everything make perfect sense, but it began to fit into a marvelous kind of cosmic relatedness..."); Joanmarie I. Davoli, Still Stuck in the Cuckoo's Nest: Why Do Courts Continue to Rely on Antiquated Mental Illness Research? 69 TENN. L. REV. 987, 1009 (2002) (asserting inability to accept that one is mentally ill is a symptom of the disease); NAT’L ETHICS COMM. OF VETERAN’S HEALTH ADMIN., ADVANCE DIRECTIVES FOR MENTAL HEALTH: AN ETHICAL ANALYSIS OF STATE LAWS & IMPLICATIONS FOR VHA POLICY (2008) 8 ("VHA Report") (asserting patients entering a mania may not recognize they are sick and may refuse treatment).
8 Davoli, supra note 5, at 1045; AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, TEXT REVISION (4TH ED. 2000) 345-428 ("DSM-IV TR") (stating one attribute of hypomania is excessive involvement in pleasurable activities with a high potential for painful consequences).
arrangements. A Ulysses arrangement is a special type of mental health advance directive (mental health directive) which enables the patient to secure treatment during an acute episode because the patient has learned from experience that episodes cause her to refuse intervention. The patient enters the arrangement when the patient has the capacity to make and communicate health care decisions and to understand the significant benefits, risks, and alternatives to proposed treatment. A Ulysses arrangement authorizes doctors to treat the patient during a future episode when the patient lacks capacity even if the episode induces the patient to refuse treatment at that time. The arrangement derives its name from the Odyssey. Ulysses was afraid the Sirens' song would lead him into danger. He directed his shipmates to tie him to the mast of his ship to protect him even if the Sirens' song manipulated him to demand to be set free. A patient who enters a Ulysses arrangement essentially requests doctors to ignore the patient's illness induced refusals.

The Uniform Law Commissioners (Commissioners) created the Uniform Health-Care Decisions Act (Uniform Act) as a comprehensive model advance directive statute for states to adopt. The Uniform Act


10 Gremmen, supra note 9, at 77.

11 Id.

12 Andreou, supra note 9, at 1.

13 Id.

14 Theo Van Willigenburg, Protecting Autonomy as Authenticity Using Ulysses Contracts, J. Med. & Phil. 395, 396 (2005) (asserting Ulysses contracts "uphold the guidance provided by one's deepest identity conferring concerns" and potentially prevent episodes from threatening the "self").

15 See Sheetz, supra note 6, at 403.

16 http://www.uniformlaws.org/Narrative.aspx?title=About%20the%20ULC (The Commissioners are all practicing attorneys, judges, legislators, legislative staff, or law professors appointed by state governments to research, craft, and promote uniform state laws in areas where uniformity is desirable and practical).

17 The Uniform Health-Care Decisions Act ("Uniform Act" or "UHCDA") was approved by the Commissioners in 1993. The Uniform Act superseded the Model Health-Care Consent Act (1982), the Uniform Rights of the Terminally Ill Act
purports to address all types of advance health care planning, including planning for episodic mental illness. However, the Commissioners focused on end-of-life decision-making, not mental illness. Therefore, the Uniform Act prevents patients from forming Ulysses arrangements and fails to address issues faced by people with mental illness. Half of the states enacted separate mental health directive statutes because they recognized that planning for end-of-life care implicates different issues than planning for mental health treatment. However, in many ways, these statutes also fail to empower patients.

This Article proposes a solution to empower people to control their mental illnesses and prevent tragedy. Part I sets forth: (1) the types of advance directives, (2) various mental health treatments, (3) an overview of civil commitment law, and (4) the benefits of mental health directives. Part II illustrates the ways in which the Uniform Act and state advance directive statutes fail to serve people with mental illness. Part III recommends the Commissioners adopt a model mental health directive statute, the key provisions of which are at Appendix A. These model provisions: (1) empower people to enter Ulysses arrangements, (2) remove obstacles to advance planning, (3) create parity for mental health care, (4) reduce stigmatization of mental illness, and (5) safeguard against fraud, undue influence, and coercion.

I. Mental Health Directives in Context

This background section puts mental health directives in context by exploring the various types of advance directives and describing the mental health treatments a patient might address in a directive. Next, this Part provides a brief introduction to civil commitment law because it is difficult

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18 UHCDA §1, cmt. (stating the health care definition is to be given the broadest construction); see Sabatino, supra note 17, at 1240; Maurice S. Fisher, Psychiatric Advance Directives and the Right to be Presumed Competent, 25 J. CONTEMP. HEALTH L. & POL’Y 386, 398 (2009) (asserting the Uniform Act affords patients the ability to make decisions concerning future mental health issues).

19 See infra Part II.

20 See infra Part II(B).

21 See infra Part II(A)(2).

22 See infra Part II(B)(4), (C)(3)(c), (D)(2), (D)(2).
to appreciate the important role for Ulysses arrangements without a basic understanding of civil commitment law. Finally, this Part enumerates the benefits of mental health directives, especially Ulysses arrangements.

A. Types of Directives

A mental health directive is a type of advance directive which allows a person to plan for future mental health treatment.23 Advance directives come in various forms.24 Instructional directives enable a patient (also known as the principal) to instruct doctors about care to be administered when the patient lacks capacity to provide informed consent.25 Proxy directives allow a patient to appoint an agent to make health care decisions for the patient when the patient is incapacitated.26 Hybrid directives contain instructions and designate agents.27 Patients use all forms of directives for physical as well as mental illness.28 When patients use directives for physical illness, it is often at the end-of-life.29 Typically, Ulysses arrangements are only necessary in the mental health context because they enable patients to consent in advance to treatment despite illness induced refusals.30 Generally, physical illness does not skew a patient's judgment and induce her to refuse necessary treatment. However, acute episodes of mental illnesses often induce patients to refuse treatment to which they would consent if they were not under the spell of an episode.31 For this reason, clinicians implement mental health directives in a different context than they implement general advance directives.

As one author stated, a general advance directive attempts to guarantee a good death while a mental health directive endeavors to secure

26 Karl A. Minninger, Advance Directives for Medical and Psychiatric Care, 100 AM. JUR. PROOF OF FACTS 3d §25 (2008).
27 La Fond & Srebnik, supra note 25, at 541
28 Minninger, supra note 26, at §7, §25.
29 See Stith, supra note 17, at 39 (asserting the Uniform Act allocates the power to choose and refuse life-sustaining treatment but marginalizes the sanctity of life with disabilities).
30 See Dunlap, supra note 24, at 352-355.
31 See supra note 5 and accompanying text.
a good life. Generally, doctors implement instructions regarding end-of-life treatment contained in a general advance directive when the principal is in a coma. The Uniform Act focuses on this typical end-of-life situation. For example, its model form contains blocks for patients to check to indicate whether to administer artificial nutrition and hydration to prolong life.

The patient in the midst of an acute mental illness episode behaves very differently than the comatose patient. Doctors will need to implement Mr. Smith's mental health directive when he is manic. Mr. Smith will not only be conscious; he will be unruly. Under the spell of his mania, he will adamantly, even physically, refuse treatment requested in his directive. Moreover, patients with terminal illness are likely to receive end-of-life treatment from doctors with whom they have an established relationship. Mental illness is different. Manic episodes induce Mr. Smith to travel. Often, people receive treatment for acute episodes of mental illness in emergency rooms or after arrest, in jails. It is essential that Mr. Smith's directive is enforceable wherever he receives care. Because the mental health context is distinct from the end-of-life context, a generic directive

32 Patricia Backlar, Anticipatory Planning for Psychiatric Treatment is not Quite the Same as Planning for End-of-life Care, 33 COMMUNITY MENTAL HEALTH J. 261, 262 (1997).
33 See David Y. Nakashima, Comment, Your Body, Your Choice: How Mandatory Advance Health-Care Directives Are Necessary to Protect Your Fundamental Right to Accept or Refuse Medical Treatment, 27 U. HAW. L. REV. 201, 202-203 (discussing In re Guardianship of Schaivo, 780 So.2d 176, 177 (Fla. Dist. Ct. App. 2001) in which the family of a woman in a persistent vegetative state battled over whether she should be kept alive through artificial means and stating that general directives address situations like comas and persistent vegetative states); Dunlap, supra note 24, at 356-358 (exploring distinctions between general advance directives and mental health directives).
34 See infra Part II.
35 See infra Part II(F)(1).
36 UHCDA §4.
38 See supra note 5 and accompanying text.
39 See PETE EARLEY, CRAZY, A FATHER’S SEARCH THROUGH AMERICA’S MENTAL HEALTH MADNESSS (G.P. Putnam's Sons 2006) 2-3 (stating the largest public mental health facility in America is the Los Angeles County jail which on any given day houses 3000 mentally disturbed inmates); Bureau of Justice Statistics, Special Report: Mental Health Problems of Prison and Jail Inmates (US Dep't of Justice, Office of Justice Programs, NCJ 213600 2006), available at http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf (stating in 2005 more than half of all inmates had a mental health problem).
statute might fail to address issues confronted by people with mental illness.\textsuperscript{40}

\textit{B. Treatments}

1. Medication

Doctors did not use psychiatric drugs, often referred to as psychotropic medication, to treat mental illness until the late 1940s after the discovery that lithium effectively treated bipolar disorder.\textsuperscript{41} Psychiatric drugs have revolutionized treatment of serious mental illness.\textsuperscript{42} Antipsychotic medications are a class of psychiatric medications doctors began using to treat psychosis in the 1950s.\textsuperscript{43} In the beginning, antipsychotic medications proved effective in limiting psychosis.\textsuperscript{44} Censuses in state psychiatric hospitals dropped dramatically in the years following the widespread use of antipsychotic drugs.\textsuperscript{45} It soon became obvious that while antipsychotic medication minimized psychosis, it also potentially caused serious side effects.\textsuperscript{46} One of the most notorious side effects of antipsychotic medication is tardive dyskinesia, a neurological disorder that is sometimes irreversible and involves involuntary, uncontrollable movements of facial muscles.\textsuperscript{47}

Because of the potentially serious side effects of various psychotropic medications, courts and legislators consider psychotropic medication to be an intrusive treatment.\textsuperscript{48} In the 1990s, the United States Food and Drug Administration approved some new antipsychotic drugs for treating patients with psychotic disorders.\textsuperscript{49} Although these medications are not always effective and do not cure the illness, they are at least as, and

\textsuperscript{40} See e.g., infra Part II (B).
\textsuperscript{41} CHRISTOPHER SLOBING ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 23 (5th ed. West).
\textsuperscript{42} Id.
\textsuperscript{43} Douglas Mossman, \textit{Unbuckling the "Chemical Straitjacket": the Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis}, 39 SAN DIEGO L. REV. 1033 (2002).
\textsuperscript{44} MICHAEL L. PERLIN, MENTAL DISABILITY LAW 400 (2d ed. Carolina Academic Press).
\textsuperscript{45} Id. at 398.
\textsuperscript{46} Id.
\textsuperscript{48} Harper, 494 U.S. at 221-22.
\textsuperscript{49} Mossman, supra note 43, at 1039 (The new drugs are clozapine, risperidone, olanzapine, quetiapine, and ziprasidone).
possibly more effective than the older antipsychotic medications.\textsuperscript{50} The new drugs are "atypical" because they alleviate psychotic symptoms with fewer side effects than the older drugs.\textsuperscript{51} Antipsychotic medications are not the only pharmacological therapies available to treat mental illness.\textsuperscript{52} Other common psychiatric drugs include antidepressant drugs.\textsuperscript{53} Moreover, lithium, the treatment of choice for bipolar disorder psychosis, is not technically an antipsychotic drug.\textsuperscript{54}

2. Electroconvulsive Therapy

Electroconvulsive therapy (ECT), generally considered to be a more invasive treatment than drug therapy,\textsuperscript{55} directs electric currents to parts of the brain which induce a series of seizures.\textsuperscript{56} Medical science has not yet developed a consensus on an explanation for the purported therapeutic benefits of ECT.\textsuperscript{57} Historically, patient advocates criticized ECT because ECT had serious side effects, such as memory loss, dental trauma, bone fractures, and skin burns.\textsuperscript{58} Today, improved technology for administering ECT combined with improvements in muscle relaxants have done away with many of the side effects.\textsuperscript{59} However, adverse side effects remain and include memory loss which can result in permanent memory gaps for some patients.\textsuperscript{60} Generally, the modern psychiatric community recognizes ECT as an effective and safe treatment for patients who suffer from severe depression.\textsuperscript{61} ECT is also often a treatment alternative for patients who are either unable to take psychiatric medications or for whom medication is ineffective.\textsuperscript{62} However, the medical community is not in unanimous

\textsuperscript{50} Id.
\textsuperscript{51} Id.
\textsuperscript{52} SLOBOGIN et al., supra note 41, at 25.
\textsuperscript{53} Id.
\textsuperscript{54} Id. at 706.
\textsuperscript{55} See infra note 466 and accompanying text.
\textsuperscript{56} Mike E. Jorgensen, Is Today the Day We Free Electroconvulsive Therapy?, 12 QUINNIPIAC HEALTH L.J. 1, 4 (2008).
\textsuperscript{58} Jorgensen, supra note 56, at 9.
\textsuperscript{59} SLOBOGIN et al., supra note 41, at 27.
\textsuperscript{60} Hull, supra note 57, at 254-256; In re Estate Austwick, 656 N.E.2d 779, 781 (Ill. App. Ct. 1995) (listing fractures, memory loss, confusion, delirium, and in rare instances, death as side effects).
\textsuperscript{61} SLOBOGIN et al., supra note 41, at 27.
\textsuperscript{62} Jorgensen, supra note 56, at 4; see e.g., Conservatorship of Waltz, 180 Cal.App.3d 722, 727 (1986) (Lithium was discontinued due to kidney injury; ECT
agreement. Critics argue that ECT is ineffective and can permanently damage the brain.

3. Psychosurgery

One state legislature defines psychosurgery as including operations referred to as lobotomy, psychiatric surgery, behavioral surgery, or any surgery performed to modify or control thoughts, feelings, or behavior rather than treat a known, diagnosed physical disease of the brain. Doctors used prefrontal lobotomy for decades to treat depression, bipolar disorder, obsessive-compulsive disorder, and schizophrenia. Today, the medical community considers prefrontal lobotomy to be a discredited, dangerous treatment whose benefits are outweighed by the significant risks of permanent brain damage. Modern psychosurgery techniques are referred to as stereotactic procedures and involve creating small lesions in different areas of the brain. Generally, even these modern procedures are rarely used and considered highly intrusive. When performed, the procedures are typically restricted to hospitalized patients with very serious mental disorders only after less intrusive therapies have failed.

C. Civil Commitment

If Mr. Smith is unable to form a Ulysses arrangement, the primary means of obtaining intervention during an episode which causes him to refuse treatment is through involuntary civil commitment. The state's authority to commit people with mental illness comes from two components

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63 Hull, supra note 57, at 251.
64 Id. at 259, 251.
65 See CAL. CODE §5325 (2012).
66 Id.
68 Id.
69 Id.
70 SLOBOGIN et al., supra note 41, at 32.
71 Id.; KAPLAN & SADOCK’S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY VOL. 1 1914 (Benjamin J. Sadock et al. 9th ed. 2009) (stating psychosurgery has been the treatment of last resort for intractable obsessive-compulsive disorder, but surgeries are increasingly being performed using magnetic resonance imaging guided stereotactic techniques).
72 Sheetz, supra note 6, at 415.
of sovereignty. The first is the police power which is the authority to maintain peace and order. The state confines to a hospital a person who is likely to be dangerous to others. The second is the parens patriae power which enables the state to protect a person whose mental illness makes her likely to harm herself or prevents her from being able to care for her basic needs.

1. Criteria

According to the U.S. Supreme Court, civil commitment imposes a massive curtailment of liberty which warrants strict commitment criteria. The Supreme Court decided that the clear and convincing evidence standard meets due process guarantees for civil commitment proceedings; the preponderance of the evidence standard is inadequate. For police power commitment, states typically require the government to show that because of mental illness the person is a danger to others. First, the state must prove the person suffers from a mental illness or disorder, often defined as a substantial disorder of the emotional processes, thought or cognition which grossly impairs judgment, behavior or capacity to recognize reality. Second, most states require proof that mental illness caused the dangerousness.

74 Id.
75 Id.
76 Hawaii v. Standard Oil, 405 U.S. 251 (1972) (stating parens patriae authority originates from the feudal beginnings of the English system in which the King was the "general guardian of all infants, idiots and lunatics").
79 SLOBOGIN et al., supra note 41, at 705
80 Id. at 723; Foucah v. Louisiana, 504 U.S. 71, 112 (1992) (Defendant who had been acquitted by reason of insanity sought release from a state hospital. Experts testified that he no longer suffered from a mental illness but because of an antisocial personality disorder might still be dangerous. The court assumed the defendant was no longer mentally ill and concluded continued confinement violated the Due Process and Equal Protection clauses); William P. Coyle, Cause of Action Against Psychiatrist in State-Operated Psychiatric Facility for Improper Civil Commitment, 1, §4 (2010).
81 SLOBOGIN et al., supra note 41, at 723; see e.g., N.M. STAT. ANN. 1978, §43-1-3 (2007).
82 SLOBOGIN et al., supra note 41, at 726.
Third, the government must prove dangerousness. For example, in Florida, the government must show a substantial likelihood that in the near future the person will inflict serious bodily harm on another person, as evidenced by recent behavior causing, attempting, or threatening such harm. This standard reveals that Florida is amongst several states which demand a finding of an overt act as a prerequisite to involuntary civil commitment. Not all jurisdictions impose an overt act requirement.

For parens patriae commitment, states generally require the government to prove mental illness caused the person to be a danger to herself or rendered her unable to provide for her basic needs. Generally, states use the same definition of mental illness or disorder as used for police power commitment. Two categories of people are potentially subject to parens patriae commitment. The first is people at risk of suicide, self-mayhem, or self-harm caused by provocation of others. The second is people whose illnesses render them unable to provide for their basic needs for food, clothing and shelter. Typically, states which impose an overt act requirement for police power commitment impose the requirement for parens patriae commitment.

For both types of involuntary commitment, almost all states require consideration of less restrictive alternatives to involuntary hospitalization.

83 Id. at 726-742 (generally addressing dangerousness); Coyle, supra note 80, at §4 (stating that in almost all states, there must be a finding the person is dangerous to himself or others); see e.g., In re BT, 891 A.2d 1193 (N.H. 2006) (requiring evidence of dangerous conduct and stating the psychiatrist’s finding of a dangerous mental condition is insufficient for involuntary commitment).
84 FLA.STAT. §394.467(2)(b) (2009).
85 See also KAN. STAT. §59-2946(f)(3)(a); Lessard et al. v. Schmidt et al., 349 F.Supp. 1078 (E.D. Wis. 1972).
87 SLOBOGIN et al., supra note 41, at 705
88 See supra notes 80 and 81 and accompanying text.
90 PERLIN, supra note 44, at 129 (This form of parens patriae commitment is often called “gravely disabled.”); Doe v. Gallinot, 486 F. Supp. 983 (C.D. Cal. 1979), aff’d, 657 F.2d 1017 (9th Cir. 1981) (stating the gravely disabled standard meets constitutional standards but cautioning against overbroad construction).
91 HERMANN, supra note 89, at 161.
92 SLOBOGIN et al., supra note 41, at 782; see e.g., FLA. STAT. §394.467(2)(b) (prohibiting involuntary commitment without a finding that all available less restrictive treatment alternatives were adjudged inappropriate); HAW. REV. STAT. §334-60.2 (requiring a finding that there is no suitable less restrictive alternative available).
This requirement is the least restrictive alternative doctrine which many view as requiring the government to select the least restrictive setting that allows for treatment and prevents danger. Commitment alternatives may include outpatient treatment, day or night treatment in a hospital, placement in the custody of a loved one, or provision of home health services.

2. Procedures

a. Emergency Detention and Screening

All states authorize involuntary emergency admission and evaluation without a full adjudicatory commitment hearing. This is the most common way a person enters the civil commitment process. Usually, either police apprehend and transport the person to the facility or family transports the person. Typically, statutes authorize police officers to detain and transport to a hospital a person the officer observes and concludes meets criteria for emergency detention and screening, which is essentially the same criteria as for involuntary commitment. Then, a doctor at the receiving facility examines the person to determine if emergency treatment is necessary to protect the safety of the person or others. States vary as to who may authorize involuntary emergency admission. For example, in Virginia, only a magistrate may authorize emergency admission, but in Florida, a doctor has the authority. States impose strict time limits during which a person may be subject to involuntary admission and examination. For example, in Florida, within seventy-two hours from the time the person arrives at the facility, a mental health professional must examine the person to determine if she meets involuntary placement criteria.

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93 HERMANN, supra note 89, at 162.
95 Id. at 806.
96 Coyle, supra note 80, at §2 (2010) (stating family often initiates commitment, and many commitments start as arrests for disorderly conduct, loitering, or trespassing).
97 See e.g., Fla. STAT. §394.463(2) (2006) (requiring an officer to take a person who appears to meet involuntary examination criteria into custody and deliver the person to the nearest receiving facility for examination).
99 SLOBOGIN et al., supra note 41, at 807.
100 Va. STAT. §37.2-809 (2010); Fla. STAT. §394.463 (2006).
101 SLOBOGIN et al., supra note 41, at 811; see e.g., Va. STAT. §37.2-809 (stating the duration of temporary detention shall not exceed 48 hours before there is a hearing).
criteria. If the person fails to meet the criteria, the facility must release her unless the person provides informed consent to remain as a voluntary patient.

b. Involuntary Admission

Every state has formal adjudicatory procedures for involuntary commitment. Each state requires a formal commitment hearing, with notice and counsel and mandates periodic reviews of the legal status of committed respondents to evaluate whether they continue to meet commitment criteria. In most states, a judge makes the decision to commit, but many states enable the respondent to request a jury trial. Commitment hearings are often dehumanizing. Many states either provide for private proceedings or allow exclusion of the respondent if being present could be harmful to the respondent. Generally, states require a review hearing after initial commitment, usually from between three months to a year after admission. A respondent can always obtain judicial review through habeas corpus.

c. Voluntary Admission

States allow for voluntary admission for inpatient mental health treatment without a hearing. According to some estimates, over half of psychiatric inpatient admissions are voluntary. Most clinicians prefer

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103 Id.
104 Slobogin et al., supra note 41, at 705.
105 See e.g., Fla. Stat. §394.467(6) (hearing to be held within five days).
107 See e.g., M.G.L.A. 123 §5 (2011) (providing the right to counsel and to present independent testimony at commitment hearings).
108 Slobogin et al., supra note 41, at 705.
109 Id. at 820; but see, Neb. Rev. Stat. §71-915 (2010) (one of a small number of states allowing an administrative board to commit).
111 See e.g., Fla.Stat. §394.467(6)(a); Slobogin et al., supra note 41, at 827.
112 Fasulo v. Arafeh, 378 A.2d 553 (1977); Slobogin et al., supra note 41, at 852.
113 See e.g., Fla.Stat. §394.459 (2005) (granting right to petition for a writ of habeas corpus to question the cause and legality of the detention).
114 See e.g., Fla. Stat. §394.4625 (providing procedures for voluntary admission and requiring discharge of voluntary patients who request discharge).
115 See Halverson, supra note 110, at 163, n. 4.
voluntary admission over involuntary admission because: (1) voluntary patients are more likely to cooperate in treatment; (2) voluntary admission is less stigmatizing; and (3) involuntary commitment proceedings squander medical and judicial resources. Generally, courts and legislatures also prefer voluntary treatment. Critics argue that admission is not truly voluntary because loved ones and doctors frequently coerce patients to admit themselves to avoid involuntary commitment, and patients often lack the capacity necessary to consent to admission.

D. Benefits of Mental Health Directives

1. Intervene Early and Avoid Involuntary Commitment

Forming a Ulysses arrangement is critical for Mr. Smith because it is the only effective intervention mechanism for episodes which obliterate his ability to recognize he needs treatment. Involuntary commitment is the most common way patients without directives obtain intervention during an episode. The first reason Mr. Smith wants a Ulysses arrangement is because treatment through involuntary commitment comes too late. One patient 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." If Mr. Smith's hypomania remains untreated, it will spiral into psychosis which could endanger his health and safety and will likely wreak havoc on his life. One author chronicled his struggles navigating the labyrinth of the mental health system for his son whose illness prevented him from recognizing he needed treatment.

My son was so out of control the nurse called hospital security. I was glad. Maybe now they will medicate him, I thought. But before

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116 Id. at 164.
118 See e.g., Matter of Tiffin, 646 N.E.2d 285 (4th Dis. 1995) (discussing a statute prohibiting statements that the patient may be subject to involuntary commitment if she does not admit herself); see Halverson, supra note 110, at 166-168 (exploring arguments against voluntary admission including potential for patient coercion and lack of an adversarial process and attorney representation).
119 See e.g., Zinermon v. Burch 49 U.S. 113, 139 (1990); PERLIN, supra note 44, at 117 (asserting that because most statutes fail to define the competency required for a valid voluntary admission, many patients who consent are incompetent).
120 Sheetz, supra note 6, at 414.
121 See infra note 122 and accompanying text.
122 Anderson, supra note 7, at 801.
123 See infra note 124 and accompanying text.
the security guard arrived, Mike dashed outside, cursing loudly. I went after him. Meanwhile, the doctor told my ex-wife it was not illegal for someone to be mentally ill in Virginia. But it was illegal for him to treat them unless they consented. There was nothing he could do. "Even if he psychotic?" She asked. "Yes." Mike couldn't forcibly be treated, the doctor elaborated, until he hurt himself or someone else.\textsuperscript{124}

The second reason he wants a Ulysses arrangement is because involuntary commitment in a state hospital is traumatic.\textsuperscript{125} Previously, he suffered symptoms of posttraumatic stress disorder after discharge from a state psychiatric hospital. He had no privacy and slept poorly because of the disturbing noises of the other patients.\textsuperscript{126} Some of the fellow patients were extremely mentally ill and had committed violent crimes in the past.\textsuperscript{127} In the state facility, loved ones could only visit once a week during limited hours.\textsuperscript{128} Some staff members verbally and even physically assaulted patients.\textsuperscript{129} He wants to consent to admission, at the first signs of hypomania, in a private hospital. He prefers treatment from his psychiatrist whom he trusts and who knows his history. His previous experiences in a private hospital were positive.\textsuperscript{130}

The third reason Mr. Smith wants to avoid involuntary commitment

\begin{footnotesize}
\begin{itemize}
\item 124 \textit{EARLEY, supra} note 39, at 16.
\item 125 December 8, 2009 Department of Justice (DOJ) Report on Investigation of the State Psychiatric Hospitals, 18 ("DOJ State Hospitals Report") ("... the State Psychiatric Hospitals... continue to provide deficient services that subject patients both to actual harm, and to excessive risk of serious harm, including: (1) inadequate protection from harm; (2) inappropriate mental health treatment; (3) inappropriate seclusion and restraints; (4) inadequate medical care...").
\item 126 \textit{Humphrey v. Cady}, 405 U.S. 504, 509 (1972) (stating civil commitment "interferes with privacy, since the patient cannot shield himself from constant observation by both his fellow patients and staff").
\item 127 DOJ State Hospitals Report, \textit{supra} note 125, at 16-19 (Even though DOJ repeatedly highlighted the State's deficient practices concerning patient on patient aggression and suicide risk, violence continued. Incidents included a patient killing another patient and a patient dying of a ruptured spleen due to blunt force trauma. Staff found the patient naked on the floor in his own urine. The mortality review never investigated how the patient suffered the trauma).
\item 128 O'Connor v. Donaldson, 422 U.S. 563, 580 (1975) ("Inmates of mental institutions, like prisoners, are deprived of unrestricted association with friends, family and community...").
\item 129 \textit{Humphrey}, 405 U.S. at 509 ("Furthermore, patients in [State] hospitals risk brutality at the hands of their fellow residents and even their attendants...").
\end{itemize}
\end{footnotesize}
through early intervention is because involuntary commitment proceedings are time-consuming, highly intrusive, and demeaning. The last time Mr. Smith was committed, he attended the adjudicatory hearing where he witnessed his ex-wife crying on the witness stand, testifying about his outrageous behavior when he was manic. He felt like a criminal watching his trial.

The final reason he wants a Ulysses arrangement is to avoid encounters with the police. People often enter the commitment process through police apprehension. For those with mental illness, police encounters can be dangerous. In Drummond v. City of Anaheim, police responded to calls from the fiancée of Drummond. Drummond, diagnosed with bipolar disorder and schizophrenia, had run out of his medication and was hallucinating and paranoid. His fiancée requested police to help her transport him to the hospital. When they arrived on the scene, officers determined Drummond was not a danger to himself or others, the criteria for involuntary psychiatric detention. The next night, Drummond's fiancée called the police again because Drummond was running into traffic. Police found unarmed Drummond in a convenience store parking lot and called for an ambulance to transport him to a hospital. Before the ambulance arrived, officers decided to take Drummond into custody "for his own safety." Officers knocked Drummond to the ground. Although one hundred and sixty pound Drummond did not resist, the two hundred and twenty-five pound officer put his knee on Drummond's back and pressed his entire weight on Drummond. The officer jammed the other knee into Drummond's neck. Gasping, Drummond told the officers he could not breathe. They laughed and bound Drummond's ankles. Within minutes, Drummond lost consciousness, sustained brain

\[\text{\textsuperscript{131}}\text{Id.}\]
\[\text{\textsuperscript{132}}\text{See HERMANN, supra note 89, at 165; SLOBOGIN et al., supra note 41, at 806.}\]
\[\text{\textsuperscript{133}}\text{See infra notes 134-147 and accompanying text.}\]
\[\text{\textsuperscript{134}}\text{Drummond v. City of Anaheim, 343 F.3d 1052, 1054 (2003).}\]
\[\text{\textsuperscript{135}}\text{Id.}\]
\[\text{\textsuperscript{136}}\text{Id.}\]
\[\text{\textsuperscript{137}}\text{Id.}\]
\[\text{\textsuperscript{138}}\text{Id.}\]
\[\text{\textsuperscript{139}}\text{Id.}\]
\[\text{\textsuperscript{140}}\text{Id.}\]
\[\text{\textsuperscript{141}}\text{Id.}\]
\[\text{\textsuperscript{142}}\text{Id.}\]
\[\text{\textsuperscript{143}}\text{Id.}\]
\[\text{\textsuperscript{144}}\text{Id. at 1055.}\]
\[\text{\textsuperscript{145}}\text{Id.}\]
damage, and fell into a coma.\textsuperscript{146} He is now in a permanent vegetative state.\textsuperscript{147}

2. Document Informed Consent, Facilitate Treatment, and Protect Clinicians

Mental health directives benefit patients because they facilitate treatment.\textsuperscript{148} The directive is a record of informed consent which enables the physician to admit and treat the patient during acute episodes when a patient lacks capacity.\textsuperscript{149} The directive benefits providers because it documents informed consent, protecting facilities and clinicians from liability for various claims based on admitting and treating a patient without informed consent.\textsuperscript{150} Under modern informed consent law, physicians must provide patients relevant information about risks and benefits of any proposed treatment and obtain the patient's informed consent before administering treatment.\textsuperscript{151}

Applying the informed consent doctrine in the mental health context is problematic.\textsuperscript{152} During certain phases of their illnesses, psychiatric patients often lack capacity required to provide informed consent.\textsuperscript{153} When a patient who has no directive becomes incapacitated, the doctor may only administer treatment if procedures are followed for involuntary admission and treatment or if a court has found the patient legally incompetent and has appointed a guardian who consents to the treatment.\textsuperscript{154} For patients with mental illness, capacity is often a fluid concept.\textsuperscript{155} There are no clear legal guidelines as to what constitutes capacity.\textsuperscript{156}

Physicians who admit and treat a patient without obtaining informed

\textsuperscript{146} \textit{Id.}
\textsuperscript{147} \textit{Id.}
\textsuperscript{149} \textit{Id.}
\textsuperscript{150} \textit{See infra} notes 166-202 and accompanying text.
\textsuperscript{151} BARRY R. FURROW et al., \textit{HEALTH LAW HORNBOOK SERIES} §6-11 (2d ed. West Group 2000); Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 269 (1990) (stating that the informed consent doctrine is firmly entrenched in American tort law).
\textsuperscript{152} SLOBOGIN et al., \textit{supra} note 41, at 290.
\textsuperscript{153} \textit{Id.}
\textsuperscript{154} \textit{Id.}
\textsuperscript{155} \textit{Id.;} Halverson, \textit{supra} note 110, at 171 (asserting that part of the difficulty with assessing competency is mental status fluctuates).
\textsuperscript{156} \textit{Id.} (asserting there is no universal definition of or method for determining competency).
consent are potentially liable for various torts, including the independent cause of action of lack of informed consent,\textsuperscript{157} assault,\textsuperscript{158} battery,\textsuperscript{159} negligence, and false imprisonment.\textsuperscript{160} Moreover, many state mental health codes allow patients to file claims against any person who violates the patient's rights, by, for example, admitting an incapacitated patient under voluntary admission procedures.\textsuperscript{161} Patients of state operated facilities may also have federal civil rights claims under 42 U.S.C. §1983 (§1983) for due process violations if the facility admitted and treated the patient without either obtaining informed consent or following procedures for involuntary admission and treatment.\textsuperscript{162} A directive enables the patient to give informed consent in advance, freeing her doctor to admit and treat her when she lacks capacity.\textsuperscript{163} The directive allows the doctor to treat a psychotic patient who does not meet involuntary commitment criteria.\textsuperscript{164} Moreover, the Uniform Act and state mental health directive statutes provide immunity from civil or criminal liability or from discipline for unprofessional conduct for clinicians and facilities who administer treatment pursuant to a directive.\textsuperscript{165}

\textit{Zinermon v. Burch} illustrates how directives protect facilities and doctors from liability.\textsuperscript{166} Police found Burch, bruised, bloodied, and disoriented, wandering along a highway and transported him to a private mental health facility designated by Florida to receive mentally ill patients.\textsuperscript{167} Staff evaluation indicated that upon arrival, Burch was hallucinating and psychotic.\textsuperscript{168} In this condition, he signed forms consenting


\textsuperscript{158} Coyle, supra note 80, at §25.


\textsuperscript{160} Coyle, supra note 80, at §24.

\textsuperscript{161} See e.g., FLA. STAT. §394.459(13).

\textsuperscript{162} See e.g., Zinermon v. Burch, 49 U.S. 113 (1990).

\textsuperscript{163} Rosenfeld, supra note 148, at 59-60.

\textsuperscript{164} See infra note 163 and accompanying text

\textsuperscript{165} UHCDATA §9(a) (providing immunity for institutions and providers acting in good faith and in accordance with generally accepted health care standards); see e.g., WASH. REV. CODE §71.32.170 (2003) (granting providers immunity for following a directive in good faith and without negligence).

\textsuperscript{166} Zinermon, 494 U.S. at 139.

\textsuperscript{167} Perlin, supra note 117, at 118 (predicting Zinermon would reduce voluntary admissions at state hospitals).

\textsuperscript{168} Zinermon, 494 U.S. at 139.
to voluntary admission. He remained in the facility for three days, was diagnosed with paranoid schizophrenia, and was administered psychotropic medication. Staff determined he needed longer-term stabilization and referred him to a state psychiatric hospital. There, he again signed forms requesting voluntary admission and treatment even though the report of the clinician at the state hospital asserted Burch remained psychotic. The Court stated that it appeared clerks simply had Burch execute voluntary admission forms, and the facility considered him a voluntary patient. He remained at the state hospital for five months. During that time, he did not have benefit of counsel. No hearing was held where he could challenge his admission and treatment.

After discharge, Burch filed a §1983 claim against doctors, administrators, and staff at the state hospital. He alleged they deprived him of liberty without due process by admitting him as a voluntary patient when they knew or should have known he lacked capacity necessary for informed consent. Florida law prohibited voluntary admission of an incapacitated patient. However, Florida failed to require a capacity determination in the course of voluntary admission. No one evaluated Burch to determine whether he had capacity to provide informed consent. Burch argued staff should have provided him procedural safeguards required by the Due Process Clause and Florida law for involuntary admission.

The Supreme Court did not rule on the merits of the §1983 claim but held it was justiciable. Exploration of the Court's analysis of case law concerning procedural due process violations is outside the scope of this

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169 Id.
170 Id.
171 Id.
172 Id. at 119–120.
173 Id. at 134.
174 Id. at 120.
175 Id. at 121.
176 Id. at 120.
177 Id. at 114-115.
178 Id. at 117, n. 3 (Burch conceded if the facility followed Florida law, it would not have violated due process because Florida law only permitted competent patients to consent to voluntary admission).
179 Id.
180 Id. at 150-151.
181 Id.
182 Id. at 124.
183 Id. at 138.
Article.\textsuperscript{184} However, the Court's discussion of mental illness illustrates the benefits of directives.\textsuperscript{185} The Court acknowledged that mental illness creates special problems regarding informed consent.\textsuperscript{186} The nature of mental illness makes it foreseeable that a person needing treatment will be unable to understand forms he is being asked to sign and unable to make a knowing and voluntary decision concerning admission and treatment.\textsuperscript{187} Even if the facility is usually justified in taking at face value a person's request for admission for medical treatment, it may not be justified in doing so without further inquiry as to a mentally ill person's request for treatment in a mental hospital.\textsuperscript{188} Moreover, many people with mental illness lack capacity required to give informed consent but don't meet commitment criteria because they are not likely to injure themselves or others and are still able to care for their basic needs.\textsuperscript{189}

The Court asserted the involuntary commitment process guards against confinement of mentally ill people who are harmless and can live safely outside the facility.\textsuperscript{190} Such confinement violates the Constitution.\textsuperscript{191} If Burch had an involuntary commitment hearing, he might not have met commitment criteria.\textsuperscript{192} A patient willing to sign voluntary admission forms but lacking capacity necessary to provide informed consent could not be relied on to protest his voluntary admission and demand adherence to involuntary placement procedures.\textsuperscript{193} Staff members were the only people able to ensure procedural protections before depriving Burch of his liberty by admitting him without his informed consent.\textsuperscript{194} The State may delegate to facility staff the power to admit patients but the staff must provide constitutionally required procedural safeguards and cannot escape liability when they fail to do so.\textsuperscript{195}

If Burch had a directive which he shared with the facility, the parties

\textsuperscript{184} Id. at 117 (The issue was whether the rule in Parratt v. Taylor, 451 U.S. 527 (1981) that deprivation of a constitutionally protected property interest caused by a state employee's random, unauthorized conduct only gives rise to a §1983 procedural due process claim if the state fails to provide an adequate post deprivation remedy).
\textsuperscript{185} Id. at 133-136.
\textsuperscript{186} Id. at 133, n. 18.
\textsuperscript{187} Id. at 133.
\textsuperscript{188} Id. at 133, n. 18.
\textsuperscript{189} Id.
\textsuperscript{190} Id. at 133-134.
\textsuperscript{191} Id. (citing O'Connor v. Donaldson, 422 U.S. 563, 575 (1975)).
\textsuperscript{192} Id. at 134.
\textsuperscript{193} Id. at 135.
\textsuperscript{194} Id.
\textsuperscript{195} Id.
might have avoided this litigation. If he did not want to be admitted even when he was psychotic, his directive could have made his refusal clear. Staff would have known voluntary admission was not an option. To admit and treat Burch, they had to adhere to procedures for involuntary placement. On the other hand, if Burch wanted doctors to admit and treat him when he was psychotic, his directive could have documented his informed consent. The facility could freely "voluntarily" admit and treat him.196 Under modern advance directive statutes, they would be immune from civil or criminal liability for administering treatment pursuant to the directive.197

Zinermon illustrates that doctors should be reluctant to admit and treat patients with mental illness whose capacity is in question without following "elaborate" involuntary admission procedures.198 As the Supreme Court acknowledged in Zinermon, a psychotic patient may not meet involuntary commitment criteria.200 Such a patient is a helpless victim of his illness because doctors must heed the patient's illness induced refusals. A directive is the only way Mr. Smith can obtain intervention during an episode which temporarily destroys his capacity. If he has no directive, the facility cannot voluntarily admit and treat him because he lacks capacity to give informed consent.201 If Mr. Smith does not meet commitment criteria, even if he is psychotic, the facility cannot admit and treat him.202 Without a directive, Mr. Smith's episode will spiral out of control.

3. Safeguard Rights to Refuse Treatment

A directive refusing psychotropic medication would have helped safeguard Burch's right to refuse treatment.203 In Cruzan v. Missouri Department of Health, the U.S. Supreme Court recognized that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment.204 Moreover, the Court stated that a competent person has a constitutionally protected right to refuse life-sustaining hydration and

196 See supra Part I(C)(2)(c).
197 See infra note 165 and accompanying text.
198 Zinermon, 494 U.S. at 140 (characterizing the involuntary admission process as "elaborate").
199 See supra Part I(C)(2)(b).
200 Zinermon, 494 U.S. at 133.
201 Id. at 117.
202 See supra note 124 and infra note 189 and accompanying text.
203 Zinermon, 494 U.S. at 117.
Cruzan became incompetent after she suffered injuries in an automobile crash. She was in a persistent vegetative state. Her parents requested hospital staff to terminate artificial nutrition and hydration. After staff refused to honor the request without a court order, her parents sought an order which the trial court issued. The trial court found that some time before the accident, Cruzan told a friend that if sick or injured, she would not want to continue life unless she could live halfway normally. The Missouri Supreme Court overturned the trial court's order, finding no clear and convincing evidence of Cruzan's desire to have life-sustaining treatment withdrawn under the circumstances.

Although the U.S. Supreme Court concluded that a competent person has a liberty interest in refusing unwanted life-sustaining hydration and nutrition under the due process clause, this conclusion did not end the inquiry. The Court had to balance Cruzan's liberty interest against Missouri's interest in preserving life and safeguarding the personal element of Cruzan's choice. Cruzan's parents argued that incompetent people also had a right to refuse life-sustaining treatment. Missouri's adoption of a heightened evidentiary requirement to ensure surrogates conformed to the patient's wishes expressed when she was competent did not violate due process.

In Washington v. Harper, the U.S. Supreme Court recognized a significant liberty interest under the Due Process Clause in avoiding unwanted administration of antipsychotic medication. Harper, diagnosed with schizophrenia, was incarcerated in a facility which provided mental health treatment to convicted felons. After he refused antipsychotic medication, his psychiatrist sought to medicate him despite his refusals.

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205 Id. at 2852.
206 Id. at 2844.
207 Id. at 2845.
208 Id.
209 Id. at 2846.
210 Id.
211 Id.
212 Id. at 2851.
213 Id. at 2852.
214 Id.
215 Id.
216 Id.
217 Id. at 2853.
219 Id. at 214.
220 Id.
Under the facility's policy, only a psychiatrist could administer medication over an inmate's refusals and only if the inmate suffered from a mental disorder and was gravely disabled or posed a likelihood of serious harm to the inmate, others, or their property. Before involuntary medication, the inmate was entitled to a hearing before a committee consisting of a psychiatrist, psychologist, and a facility administrator, none of whom were currently involved in the inmate's treatment or diagnosis. If the committee determined the inmate suffered from a mental disorder and was gravely disabled or dangerous, the psychiatrist could medicate the inmate against the inmate's will. The policy required periodic review for continued medication.

Harper claimed due process prohibited Washington from overriding his refusal of antipsychotic medication unless he had been found incompetent, and then only if the factfinder made a substituted judgment that, if competent, Harper would have consented. The Court disagreed. The policy ensured antipsychotic medication would be ordered only if in Harper's medical interests given the needs of confinement. Washington's policy was a rational means of furthering its legitimate interests of protecting safety and treating Harper. Harper also claimed Washington's nonjudicial method of determining facts was insufficient under due process. To determine the process due, the Court balanced Harper's interests against Washington's interests and the value of Washington's procedural requirements. The Court decided that allowing medical professionals, instead of a judge, to make the decision to involuntarily medicate adequately protected and likely even better served Harper's interests. Procedural protections such as independent decision-makers and rights to be present and cross-examine witnesses at an adversary hearing made Washington's policy satisfy due process.

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221 Id. at 215.
222 Id.
223 Id.
224 Id. at 216.
225 Id. at 217, 222 (also claiming violations of the Equal Protection and Free Speech Clauses of both the Federal and State Constitutions and state tort law).
226 Id. at 222.
227 Id.
228 Id. at 224 (applying the reasonableness standard because of the prison context).
229 Id. at 226.
230 Id. at 217, 229.
231 Id. at 229.
232 Id. at 231.
233 Id. at 233.
234 Id. at 235.
Although *Cruzan* and *Harper* rely on due process to support the rights to refuse life-sustaining treatment and psychotropic medication, other constitutional basis support the right to refuse treatment, including the "penumbral" right to privacy's protection of bodily integrity. Not only does the U.S. Constitution support a person's right to refuse psychotropic medication and other forms of mental health treatment, the common law doctrine of informed consent, state statutes, and state constitutions do as well.

The right to create an advance directive is implicit in the right to refuse treatment because a directive enables a person with capacity to prevent administration of unwanted treatment when the person lacks capacity. *In re Rosa M.* illustrates why directives help safeguard rights to refuse treatment. In *In re Rosa M.*, the director of a psychiatric hospital applied for an order authorizing ECT on an involuntarily committed patient. Rosa M.'s psychiatrist opined that Rosa M's mental illness was only responsive to treatment including ECT. She lacked capacity to consent to ECT. State regulations required authorization from an immediate family member or a court order to administer ECT to a patient who lacked capacity to consent. When she had capacity, Rosa M. had executed a directive refusing ECT. This directive documented and therefore protected her right to refuse treatment. The court held that absent an overriding state interest, the hospital was required to honor her competent rejection of ECT even after she had lost capacity.

4. Avoid Guardianship

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235 See *supra* notes 204-234 and accompanying text.
236 SLOBOGIN et al., *supra* note 41, at 980 (other basis were the First and Eighth Amendments and Equal Protection).
237 *Cruzan*, 497 U.S. at 2850-2851.
238 *Id.*
240 Sheetz, *supra* note 6, at 423.
242 *Id.*
243 *Id.*
244 *Id.*
245 *Id.*
246 *Id.*
247 *Id.* at 545.
248 *Id.*
One option for a person with mental illness to obtain treatment during episodes which destroy capacity necessary to provide informed consent is guardianship. First, the court receives a petition to determine the incompetency of the ward and appoint a guardian. Many states allow any interested person to initiate guardianship proceedings. After the court determines the person is incompetent, a hearing takes place to determine whether the person needs a guardian. If there is clear and convincing evidence of the need for a guardian, the court appoints one either to make all legal decisions for the ward or only specific types of decisions the ward is incompetent to make.

One advantage of a mental health directive is its potential to avoid guardianship. People with mental illness often experience long periods of full capacity and are capable of governing their lives and treatment. Mr. Smith does not want "any interested person" to initiate proceedings for a judge to find him incompetent and appoint a guardian to make his decisions. Incompetency adjudications, a form of deviance labeling, have seriously detrimental societal consequences and cause significant psychological damage to the ward. Mr. Smith prefers to execute a directive in which he appoints an agent he trusts to make decisions in line with his values. Because it may be difficult for any directive to address every situation that may arise, Mr. Smith can engage in ongoing dialogue with his agent to ensure his agent understands his thoughts about treatment. If the directive fails to address an issue, his agent can make decisions in line with Mr. Smith's values. There will be no need for the court to appoint a

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249 HERMANN, supra note 89, at 214.
250 Id.
251 Id.
252 Id. at 216.
253 Id. at 216-217.
254 See Winick, supra note 130, at 84.
255 Sheetz, supra note 6, at 404; Miller, supra note 37, at 731; see e.g., DSM-IV Tr, supra note 8, at 345 (explaining that bipolar disorder is episodic); TERRI CHENEY, MANIC: A MEMOIR (William Morrow 2008) (memoir of a highly successful entertainment lawyer with bipolar disorder).
256 See supra note 251 and accompanying text.
257 Winick, supra note 130, at 84; see Bruce J. Winick, The Side Effects of Incompetency Labeling and the Implications for Mental Health Law, 1 PSYCHOL. PUB. POL’Y & L. 6, 41 (1995); Miller, supra note 37, at 736.
258 Winick, supra note 130, at 85.
259 Id. at 82.
260 See Dunlap, supra note 24, at 348 (asserting a combination between an instructional and proxy directive may be the most effective way to effectuate the patient's desires).
5. Promote Better Decision-Making and Self Responsibility and Provide Useful Information

Mr. Smith is in the best position to make decisions about his prospective care when he is stable and unaffected by an episode. The mental health directive allows the patient when he is stable to determine the care he should receive during an episode, which renders him unable to evaluate his treatment needs. Research indicates that mental health directives provide doctors clinically useful information which can expedite and improve care. For example, a directive would notify doctors that administering lithium to Mr. Smith would be dangerous. When Mr. Smith is altered by his illness, he will not remember to inform doctors that he suffered lithium toxicity.

The process of creating a directive gives the patient a sense of empowerment and encourages self-responsibility. This advance planning process is therapeutic because it provides patients opportunities to analyze the patterns of their illnesses and prevent crises. Studies indicate patients experience a high level of satisfaction with intervention administered pursuant to a mental health directive. Researchers theorize that patients with mental health directives perceive treatment to be more self-determined because directives allow patients to actively co-author individualized mental-health crisis prevention plans.

II. ANALYSIS OF KEY PROVISIONS OF THE UNIFORM ACT AND STATE STATUTES

This Part explains key provisions of the Uniform Act and state

\[\text{\textsuperscript{261}}\text{ See Winick, supra note 130, at 85.}\]
\[\text{\textsuperscript{262}}\text{ See Sheetz, supra note, at 404; Fisher, supra note 18, at 402.}\]
\[\text{\textsuperscript{263}}\text{ Miller, supra note 37, at 735-737.}\]
\[\text{\textsuperscript{264}}\text{ Debra S. Srebnik et al., The Content and Clinical Utility of Psychiatric Advance Directives, 56 PSYCHIATRIC SERVICES 592 (2005), http://ps.psychiatryonline.org.}\]
\[\text{\textsuperscript{265}}\text{ Sheetz, supra note 6, at 406-407.}\]
\[\text{\textsuperscript{266}}\text{ Winick, supra note 130, at 81-82.}\]
\[\text{\textsuperscript{267}}\text{ Eric B. Elbogen et al., Effectively Implementing Psychiatric Advance Directives to Promote Self-Determination of Treatment Among People with Mental Illness, 13 PSYCHO. PUB. POL’Y & L. 273, 275, 285 (2007) (reporting on a study revealing that subjects reported a high level of satisfaction with a facilitated, one-on-one psychiatric directive intervention).}\]
\[\text{\textsuperscript{268}}\text{ Id. at 274-275.}\]
advance directive statutes and explores how the Uniform Act, with its focus on end-of-life, ignores the needs of people with mental illness. For example, the Uniform Act prevents people from forming Ulysses arrangements and removes safeguards against fraud, coercion, and undue influence that are particularly important in the mental health context. Moreover, this Part illustrates that key provisions of state advance directive statutes also fail to empower people with mental illness.

A. Separate Mental Health Directive Statutes or a One-Size-Fits-All Approach?

1. The Uniform Act's One-Size-Fits All Approach

The Commissioners created the Uniform Act because state law for advance directives was inconsistent and confusing.269 At the time the Uniform Act was issued, every state had one or more statutes regarding health care powers of attorney, living wills, or other forms of proxy decision-making.270 Often these state statutes were incomplete because they only addressed a narrow set of issues, or the statutes were overly formalistic and difficult for patients to follow.271 The primary goals of the Uniform Act were to support patient autonomy by creating a simplified uniform process to facilitate use of advance directives and provide a method for making health care decisions when patients fail to plan.272 The Uniform Act purported to be a comprehensive statutory scheme addressing all health care planning which dispensed with unnecessary obstacles to directive formation.273 No longer would separate statutes be necessary to govern living wills versus health care powers of attorney.274

2. Half of the States Have Separate Mental Health Directive Statutes

Eight states adopted the Uniform Act.275 Half of the states, including

270 Sabatino, supra note 17, at 1238.
271 Id.
272 English, supra note 269, at 20.
273 Id.
274 Id.
275 ALASKA STAT. §13.52.010 to 13.52.395 (2012); DEL. CODE ANN. Tit. 16, §2501 to 2518 (2012); HAW. REV. STAT. §327E-1 TO 327-16 (2012); MISS. CODE ANN. §41-41-201 TO 41-41 229 (2012); N.M. STAT. ANN. §24-7A1 TO 24-7A- 18 (2006); WYO. STAT. ANN. §3-5- 201 TO 3-5-213 (LEXIS NEXIS 2001); ALABAMA,
some that adopted the Uniform Act, also enacted separate mental health directive statutes.\textsuperscript{276} Generic directive statutes regulate mental health directives in the remaining states.\textsuperscript{277} Like the Uniform Act, generic directive statutes often focus on end-of-life decision-making and do not address mental illness.\textsuperscript{278} For example, Florida has no separate mental health directive statute.\textsuperscript{279} The legislative findings of Florida's generic directive statute address end-of-life and palliative care but fail to mention psychotropic medication or ECT.\textsuperscript{280} Similarly, the recommended statutory forms in Illinois, Wisconsin, and Alaska for health care instructions make the instructions effective when the physician determines the patient has a terminal condition or is in a persistent vegetative state.\textsuperscript{281} This provision is inappropriate for patients who need their mental health directives to take effect when they lose capacity due to an acute episode. Moreover, the provision is potentially confusing and upsetting for otherwise healthy patients with mental illness.

3. Analysis

a. The Uniform Act Fails People with Mental Illness

The Commissioners' goal of creating a comprehensive, simple system for advance health care planning is laudable. However, end-of-life issues are different from issues implicated in mental illness. Generally, a patient with terminal cancer whose directive instructs her physician to terminate artificial nutrition after she enters a vegetative state would want authority to revoke the directive at any time. This patient has no need for irrevocable instructions. However, Mr. Smith's manias cause him to refuse treatment and will induce him to revoke his directive.\textsuperscript{282} Mr. Smith needs to


\textsuperscript{277} See VHA Report, supra note 5, at 3.

\textsuperscript{278} See infra Part I(A).

\textsuperscript{279} Fla. Stat. §§765.101 to 765.205.


\textsuperscript{282} See supra note 5 and accompanying text.
make his directive irrevocable during periods of incapacity. State statutes created for situations like the Terri Schiavo case do not address Mr. Smith's needs.

Generally, the Uniform Act and generic directive statutes address end-of-life issues and leave a void of guidance on basic mental health issues. This void burdens patients and hospitals with unnecessary litigation. For example, because Massachusetts had no mental health directive statute, in Cohen v. Bolduc, the Massachusetts Supreme Court had to address whether the state general health care proxy statute authorized an agent to commit a principal to a mental health facility. The patient's proxy was activated in the summer of 2000. The Massachusetts Supreme Court did not issue its decision until January of 2002. Undoubtedly, the patient, her family, and her hospital incurred unnecessary time, expense, and emotional strain when the parties had to bring their case all the way to the state Supreme Court to answer a basic mental health question.

In states without mental health directive statutes, unelected judges must make policy decisions better left to elected lawmakers. When a court applies a generic directive statute in a mental health crisis, the court is in the untenable position of interpreting a law intended to address end-of-life care, not mental illness. The Cohen Court had to decide whether commitment authority was implicit in the generic directive statutory scheme. The health care proxy statute defined "health care" to include any treatment, service or procedure to diagnose or treat the patient's physical or mental condition. From this reference to mental conditions, the Cohen Court decided the legislature did not intend to limit the agent's authority. As Cohen acknowledged, the legislature had never addressed the commitment issue. The Cohen Court was forced to survey other states' mental health directive statutes which were split as to whether an

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283 See supra note 33 for explanation of Terri Schiavo case.
284 See e.g., supra Part II(A)(2).
285 See e.g., infra note 286 and accompanying text.
287 Id. at 716.
288 Id. at 714.
289 See infra notes 291-302 and accompanying text.
290 See infra notes 291-302 and accompanying text.
291 Cohen, 760 N.E.2d at 719, 720 (stating "we must determine whether authority to commit is implicit in our statutory scheme").
292 Id. at 720.
293 Id. (stating that by referring to "mental condition" the legislature contemplated an agent authorizing some mental health treatments without limitation).
294 Id. at 718.
agent possessed commitment authority. Cohen looked to the Uniform Act which only allows an agent or surrogate to commit if the principal expressly provided commitment authority in a written directive. Other state legislatures whose statutory definitions of health care included treatment of mental conditions decided that an agent did not have authority to commit. Therefore, the Cohen Court's conclusion that the general proxy statute's broad health care definition necessarily implied an agent's authority to commit was unfounded.

In a legislative vacuum, the Cohen Court made a policy decision that denying an agent authority to commit her principal when her principal expressed no disagreement frustrated patient autonomy. Cohen made this policy decision despite the fact that several state advance directive statutes prohibit an agent from committing a principal. Moreover, the Uniform Act prohibits an agent from committing a principal unless the principal provides express written commitment authority. Reasonable lawmakers disagree on the issue. Cohen underscores the need for a model mental health directive statute for state elected officials to adopt, enabling elected lawmakers, not unelected judges, to legislate.

B. Revocation and Ulysses Arrangements

1. The Uniform Act Prevents Ulysses Arrangements

Under the Uniform Act, a principal, with or without capacity, can revoke the designation of an agent or surrogate in a signed writing or by personally informing her doctor. Even if she is incapacitated, the principal may revoke any other portion of the directive in any manner that communicates intent to revoke. An advance directive that conflicts with an earlier directive revokes the earlier to the extent of the conflict. The Uniform Act does not allow people to form irrevocable directives.

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295 Id. at 718-719.
296 Id. at 718, n. 14.
297 Id. at 718, n. 15.
298 Id. at 721.
299 See supra note 297 and accompanying text.
300 UHCDA §13.
301 See supra notes 296-297 and accompanying text.
302 See infra Part III.
303 UHCDA §3.
304 Id.
305 Id.
2. Most States Prohibit Revocation from Incapacitated Patients

In the majority of the states, a principal may revoke a general advance directive at any time even if she has lost capacity. However, most states with mental health directive statutes only allow a patient with capacity to revoke a mental health directive. Washington only allows an incapacitated principal to revoke a directive if she elected at the time of execution to be able to revoke the directive when incapacitated.

3. Washington's Approach

In Washington, when a principal's mental health directive: (1) remains irrevocable during incapacity and (2) consents to inpatient mental health treatment, but the principal refuses admission, the facility may admit the patient despite illness induced refusals. There are strict criteria for such admission. First, two doctors must determine the principal lacks capacity. The Washington statute does not address whether a principal's refusal of admission in contravention of express instructions in her directive supports a determination of incapacity. Second, the doctor must obtain the informed consent of the principal's agent if one is designated. Third, the doctor must make a written finding that the principal needs inpatient evaluation or treatment which cannot be accomplished in a less restrictive setting. Fourth, the doctor must document in the principal's medical record a summary of findings and recommendations.

If the doctor determines the principal has capacity, the principal may only be admitted or remain in inpatient treatment if the principal consents or

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306 See VHA Report, supra note 5, at 9 (asserting in 36 out of 50 states, incapacitated patients may revoke a general advance directive).
307 Id. (asserting 18 out of 25 states with mental health directive statutes only allow revocation from patients with capacity).
308 WASH. REV. CODE §71.32.080(1)(a).
309 Id. §71.32.140 (2009).
310 Id. §71.32.140(2).
311 Id. §71.32.140(2)(a), (3) (For simplicity, the term "doctor" is used. The statute requires a physician or psychiatric registered nurse practitioner, in conjunction with another health care provider, to make the incapacity determination. If the admitting physician/nurse practitioner is not a psychiatrist/psychiatric advanced registered nurse practitioner, a mental health professional shall assess the principal to determine continued need for inpatient evaluation or treatment).
312 Id. §71.32.140.
313 Id. §71.32.140(2)(b).
314 Id. §71.32.140(2)(c).
315 Id. §71.32.140(2)(d).
is detained under involuntary commitment law. If two doctors determine the principal lacks capacity, and the principal continues to refuse admission, the principal may seek injunctive relief. If, at the end of the timeframe the principal consented to inpatient treatment, but in no case more than fourteen days after admission, the principal has not regained capacity or has regained capacity but refuses treatment, the facility shall release the principal unless the principal is detained under involuntary commitment law.

In Washington, the incapacitated principal's instructions in her directive control with one significant exception. Even if the principal's irrevocable directive consents to inpatient treatment despite illness induced refusals, the facility shall discharge the principal if she "takes actions demonstrating a desire to be discharged, in addition to making statements requesting to be discharged." The facility shall not use restraint in any way to prevent discharge. This limitation essentially prevents patients from entering Ulysses arrangements.

4. Analysis: Empowering Patients to Create Individualized Plans

a. The Uniform Act and Washington Prevent Ulysses Arrangements

The Uniform Act prevents patients from forming irrevocable directives which illustrates its focus on end-of-life care, not mental illness. Any patient able to communicate a change of mind about whether to end administration of artificial hydration should be able to do so. Ability to communicate renders a capacity determination unnecessary. The case is different for patients with mental illness who can communicate even when they lack capacity. A typical patient will only use her general advance directive one time period during her life to govern end-of-life care. However, a patient may employ her mental health directive multiple times.

316 Id. §71.32.140(4)(a).
317 Id. §71.32.140(4)(d).
318 Id. §71.32.140(5).
319 Id. §71.32.140(6)(b).
320 Id. §71.32.140(6)(b).
321 Id. §71.32.140(6)(b).
322 See Wa. F. B. Rep., S.B. 5223, Reg. Sess., at 2 (2003) (asserting that because this is a voluntary admission, a patient who takes action to leave and demands discharge must be discharged unless she meets involuntary commitment criteria but failing to explain why the patient's illness induced demands override her consent in her directive).
323 UHCDA §3.
324 Dunlap, supra note 24, at 356.
over her life, each time she endures an episode. Assume Mr. Smith's directive requests inpatient treatment when an acute episode destroys his capacity. If Mr. Smith can revoke the directive when he lacks capacity, the directive is a dead instrument. Mania will induce him to revoke the directive. Only a Ulysses arrangement enables him to provide informed consent to treatment despite his illness induced refusals.

Even the Washington approach, noted for its progressive support of patient empowerment, falls short of authorizing Ulysses arrangements for two reasons. First, Washington requires a facility to discharge an incapacitated patient who takes action and make statements demonstrating desire to be discharged, even if discharge contravenes the patient's irrevocable directive. The following illustrates why this prevents Ulysses arrangements.

Mr. Smith executes an irrevocable mental health directive consenting to inpatient treatment which becomes active pursuant to its terms. His daughter drives Mr. Smith to a hospital where he refuses admission. The admitting psychiatrist follows the Washington protocol and determines Mr. Smith lacks capacity and needs the inpatient treatment his directive dictates he receive. Hypomanic Mr. Smith does not recognize that he is ill. He demands discharge through words and actions. Psychiatrists determine that although Mr. Smith lacks capacity, he fails to meet involuntary commitment criteria. Left untreated, his hypomania will escalate to psychosis. Despite this inevitability, Washington requires discharge.

Second, Washington fails to assist doctors assess capacity when a principal's illness induced refusals contradict her directive. When a principal arrives at a facility, but due to an episode refuses admission, despite consent to inpatient treatment in an irrevocable directive, Washington requires a capacity assessment. If doctors determine the principal lacks capacity, they may admit the principal only if they follow

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325 Id.
326 See supra notes 120-147 and accompanying text.
327 See Sheetz, supra note 6, at 401 (stating Washington authorizes Ulysses directives and advocating other states adopt provisions similar to Washington's).
328 WASH. REV. CODE §71.32.140(6)(b).
329 Id. §71.32.140(2).
330 Id. §71.32.140(6)(b).
331 Id. §71.32.140; see also §71.32.110 (setting forth procedures for making capacity determinations but providing no assistance in making the substantive determination).
332 Id. §71.32.140(2).
strict protocols. If the principal has capacity, doctors must discharge the principal unless the principal consents to inpatient treatment. Washington fails to recognize that a person who refuses care requested in her irrevocable directive necessarily exhibits substantial evidence of incapacity.

In this way, Washington ignores several factors which make doctors reluctant to admit patients whose illnesses cause them to refuse treatment. First, only a small percentage of patients with mental illness execute mental health directives. Therefore, most psychiatrists have little experience implementing directives. Second, psychiatrists are very familiar with the strict criteria for involuntary admission and treatment. Unless Washington instructs otherwise, doctors will likely automatically apply this strict criteria. Third, because capacity is fluid, capacity determinations are not black and white decisions. When in doubt, doctors will "err on the side of caution" and discharge patients whose illnesses cause treatment refusals regardless of consent to treatment in an irrevocable directive. This caution prevents necessary intervention. Honoring Mr. Smith's consent to early intervention in an irrevocable directive not only respects his autonomy, it potentially saves his life.

b. States that Do Not Allow Patients to Choose Stigmatize

However, patients should not be forced to form irrevocable directives. The majority of states with separate mental health directive statutes reinforce the stigma of mental illness when they do not allow patients to choose whether to make their directives revocable during periods of incapacity. The purported rationale for prohibiting incapacitated patients from revoking mental health directives is that preferences articulated in a written directive more likely reflect the authentic values of the patient than choices made when the patient is incapacitated. The

333 Id. §71.32.140(2).
334 Id. §71.32.140(4)(a).
335 See Maria J. O'Connell & Catherine H. Stein, Psychiatric Advance Directives: Perspectives of Community Stakeholders, 32 ADMIN. & POL’Y IN MENTAL HEALTH 241, 244 (2005) (Only 6.8% of people with schizophrenia surveyed had a mental health directive); Jeffrey Swanson et al., Psychiatric Advance Directives Among Public Health Consumers in Five US Cities: Prevalence, Demand and Correlates, 34 J. AM. ACAD. PSYCHIATRY & L. 43, 54 (2006) (Between four and thirteen percent of mental health patients surveyed had directives).
336 See supra Part I (D) (2).
337 See supra notes 306-308 and accompanying text.
338 VHA Report, supra note 5, at 9; Roberto Cuca, Ulysses in Minnesota: First Steps Toward a Self-Binding Psychiatric Advance Directive Statute, 78 CORNELL
rationale is based on the premise that restricted revocation during periods of incapacity best serves patient autonomy because it respects a patient's choices made when she was able to thoroughly consider the risks and benefits of treatment options.\footnote{VHA Report, \textit{supra} note 5, at 9.}

Patients should be free to choose whether they may revoke their mental health directives when incapacitated for several reasons. First, the premise that a patient's preferences articulated in a written directive more likely reflect the patient's true wishes than preferences stated when the patient has lost capacity applies equally for general advance directives as it does for mental health directives.\footnote{Gallagher, \textit{supra} note 9, at 778; VHA Report, \textit{supra} note 5, at 9.} Therefore, there is no policy reason to restrict revocation of mental health directives if the state does not restrict revocation of general advance directives. Most states do not restrict revocation of general advance directives.\footnote{Srebnik, \textit{supra} note 25, at 592.}

Second, restricted revocation only for mental health directives stigmatizes mental illness and undermines parity for mental health care. In one study, almost half of surveyed patients indicated they wanted authority to revoke their mental health directives during periods of incapacity.\footnote{Srebnik, \textit{supra} note 25, at 592.} In states that do not allow incapacitated patients to revoke their mental health directives, patients only have the power to create self-binding directives.\footnote{See \textit{supra} note 306-308 and accompanying text.} They cannot create individualized mental health care plans. One of the Commissioners' goals was to encourage patients to form advance directives.\footnote{Sabatino, \textit{supra} note 17, at 1238.} Patients have greater autonomy if they provide advance instructions and designate agents who understand their preferences.\footnote{Id. at 1239.} Patients who want the power to revoke their mental health directives when they lack capacity may refrain from advance planning if their only option is to form an irrevocable directive.

\section*{C. Execution}

\subsection*{1. The Uniform Act's Minimal Execution Requirements}

Under the Uniform Act, an "individual instruction" is the principal's directions about her health care.\footnote{UHCDA §1(9).} Oral instructions are valid.\footnote{UHCDA §1(9). The
patient's physician need only record the oral instructions in the principal's medical record.\textsuperscript{348} A patient may issue written instructions without any witnesses, notarization, or mandatory form or language.\textsuperscript{349}

The Uniform Act permits three types of proxies: surrogates, guardians, and agents to make health care decisions for patients who lack capacity.\textsuperscript{350} A principal's designation of an agent (a power of attorney for health care) must be in a signed writing.\textsuperscript{351} The only limitation on who may serve as an agent prohibits owners, operators, or employees of residential long-term health care institutions where the principal receives care from being agents, unless they are related to the principal.\textsuperscript{352} Designation of an agent need not be witnessed or notarized.\textsuperscript{353} A surrogate is an individual authorized to make the principal's health care decisions when the principal lacks capacity, and no agent or guardian has been designated or is available.\textsuperscript{354} A patient may select a surrogate orally by informing her doctor.\textsuperscript{355}

The Uniform Act defines capacity as an individual's ability to understand the significant benefits and risks and alternatives to proposed health care and to make and communicate a healthcare decision.\textsuperscript{356} There is a rebuttable presumption of capacity.\textsuperscript{357} No clinician determination of capacity is necessary to create a directive.\textsuperscript{358}

2. States Impose More Execution Requirements

Every state that implemented the Uniform Act imposed witnessing requirements for all directives, presumably to protect against fraud and coercion.\textsuperscript{359} The need to protect against coercion in the context of mental health directives is arguably greater than for general advance directives.\textsuperscript{360} Scholars and legislatures have recognized the potential for family and

\textsuperscript{347} Id. §2(a).
\textsuperscript{348} Id. §7(b); Sabatino, supra note 18, at 1243.
\textsuperscript{349} UHCDCA §2.
\textsuperscript{350} Id. §1(2), (4), (17); see Sabatino, supra note 18, at 1242.
\textsuperscript{351} UHCDCA §2(b).
\textsuperscript{352} Id. §2(b) & cmt.
\textsuperscript{353} Id.
\textsuperscript{354} Id. §5(a).
\textsuperscript{355} Id.
\textsuperscript{356} Id. §1(3).
\textsuperscript{357} Id. §1(b).
\textsuperscript{358} Id.
\textsuperscript{360} See infra notes 361-365 and accompanying text.
doctors to use mental health directives as instruments to coerce patients to accept certain treatments.361 Patients with mental illness are especially vulnerable to coercion because they may perceive the threat of involuntary commitment or forced administration of psychotropic medication.362 The potential for undue influence may be why almost all states with separate mental health directive statutes have restricted who may serve as a witness.363 Several states prohibit members of a principal's family and treatment team members from serving as witnesses.364 Typically, witnesses must attest to certain observations such as that the principal executed the directive voluntarily.365

The Uniform Act’s definition of capacity366 is similar to the definition of capacity used in many mental health directive statutes.367 Most states, like the Uniform Act,368 have a statutory presumption of capacity to execute any directive, including a mental health directive.369 However, in Louisiana, an individual wishing to create a mental health directive, but not a general advance directive, must obtain a clinician's written attestation that she examined the principal and determined the principal had capacity.370

3. Analysis: Balancing Simplification with Protection

361 Dunlap, supra note 24, at 378 (noting states enacted penalties against people who coerce a patient into or out of executing a mental health directive); Miller, supra note 37, at 738; Lester J. Perling, Health Care Advance Directives: Implications for Florida Mental Health Patients, 48 U. MIAMI L. REV. 193 (1993).
363 VHA Report, supra note 5, at 5 (stating concerns over coercion and undue influence caused all of the states with separate statutes except Montana to restrict who may serve as witnesses).
364 Id. (listing Arizona, Hawaii, Idaho, Illinois, Kentucky, Michigan, New Mexico, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, and Washington, as excluding family members and all of the previously listed states in addition to Wyoming as excluding treatment team members).
365 Id. (stating most mental health directive statutes require witness attestation except Indiana, Maine, Maryland, Montana, and Washington).
366 UHCD A §1(3).
368 UHCD A §11(b).
369 Winick, supra note 130, at 68 n. 39; Sheetz, supra note 6, at 413.
370 LA. REV. STAT. ANN. §28:224 (2001); Sheetz, supra note 6, at 414.
a. Elimination of Witnessing Requirements Poses Undue Risks

The Commissioners’ elimination of a witnessing requirement removes an important protection against undue influence, coercion, and fraud.\textsuperscript{371} Witness attestation that the principal showed identification or that the witness knows the principal and has no reason to suspect the principal executed the directive under undue influence or fraud helps ensure execution was voluntary. Moreover, the Commissioners should remove from the potential witness pool people who may have conflicts of interest. Allowing family and treatment team members who often hold strong opinions about optimum treatments to witness the directive presents unnecessary risks of coercion and undue influence.\textsuperscript{372} Agents should not serve as witnesses because agents have authority to make all health care decisions once the principal lacks capacity.\textsuperscript{373} Agents should not witness the same document which gives them this power.\textsuperscript{374} People affiliated with health care facilities in which the principal receives treatment should not serve as witnesses because they have financial interests in administering care.

b. Elimination of the Signed Writing Requirement Removes Safeguards

The Uniform Act has been commended for permitting patients to orally designate surrogates and issue treatment instructions because this flexibility is practical, realistic and removes obstacles to advance health care planning.\textsuperscript{375} Most patients don't want to think about end-of-life care until they are forced to confront the issue and therefore don't create written directives.\textsuperscript{376} The typical patient may say something like, "if I lose capacity, my daughter should make decisions concerning my care."\textsuperscript{377} The Uniform Act enforces oral instructions and designations of surrogates for this practical reason.\textsuperscript{378} However, for patients with mental illness, the risks

\textsuperscript{371} Stith, \textit{supra} note 17, at 47-48 ("The streamlined procedures appear to sacrifice safeguards for efficiency").
\textsuperscript{372} VHA Report, \textit{supra} note 5, at 5-6.
\textsuperscript{373} UHCD A §1(2).
\textsuperscript{374} See e.g., \textit{WASH. REV. CODE} §71.32.090(1) (2003).
\textsuperscript{375} Sabatino, \textit{supra} note 17, at 1244-45.
\textsuperscript{376} \textit{FURROW}, \textit{supra} note 151, at 849 (stating that only ten to twenty-five percent of Americans have documented end-of-life choices or appointed an agent).
\textsuperscript{377} Sabatino, \textit{supra} note 17, at 1244-45.
\textsuperscript{378} Id.
posed by enforcing oral instructions and designations of surrogates do not justify the purported benefits.\footnote{See infra notes 380-391 and accompanying text.}

First, people with mental illness need portable instructions and designations of agents. Mr. Smith's manias have landed him in emergency rooms and in health clinics in county jails all over the country.\footnote{See supra note 39 and accompanying text.} The Uniform Act makes enforceable Mr. Smith's oral instructions that Mr. Smith's physician records in his medical records.\footnote{UHCDA § 2(a).} Oral instructions are not as readily portable as a written directive.\footnote{Sabatino, supra note 17, at 1243.}

Second, oral instructions are less reliable and more susceptible to misinterpretation and fraud than written directives.\footnote{Id.} Because mental illnesses are complicated,\footnote{DSM-IV TR, supra note 8.} patient instructions are often nuanced. A patient may make off-the-cuff remarks under the stress of an impending crisis. The Uniform Act grants the physician, who has financial interests in administering care and strong opinions about optimum treatments, the authority to record and therefore interpret inherently unreliable oral remarks.\footnote{UHCDA §7(b).} Even for the vast majority of physicians who are ethical, enforcing oral instructions risks misinterpretation of a patient's wishes. Misinterpretation is not the only risk because not all doctors are ethical. Mental health care is particularly susceptible to fraud because: (1) strict patient confidentiality makes abuse hard to discover; (2) the practice of mental health medicine is highly subjective; and (3) mental health patients are often less able to chronicle their treatment than other patients.\footnote{Rosenfeld, supra note 148, at 77; Pamela H. Bucy, Health Care Fraud and the False Claims Act, A.B.A. CONTINUING LEGAL EDUC. 9 (1998) (asserting reasons why patients in the mental health context are especially vulnerable to provider fraud).} Therefore, in the mental health sector, enforcing oral instructions recorded by the patient's physician creates opportunities for fraud and abuse.\footnote{Id.}

Third, a signed writing requirement protects doctors from fraudulent claims that they administered treatment without informed consent. The written, signed directive documents informed consent to all treatment administered pursuant to its terms.\footnote{See supra Part I(D)(2).} A physician's notes recording a
patient's oral remarks may not provide sufficient evidence of informed consent if the patient claims she never consented.

Finally, determining the precise moment an acute episode causes a person to lose the capacity required to issue binding oral instructions is difficult. Mr. Smith is concerned he will utter oral instructions to his doctor when he is hypomanic but technically has capacity. Experience has taught him that during hypomania, he will refuse treatment even though he would have requested treatment if he were not under the spell of an episode. Previously when he was hypomanic, he associated with unstable people with whom he would not associate when he was well. Mr. Smith is concerned that when hypomanic, he will orally select a surrogate he would never have chosen when he was stable. Requiring a written, signed directive better ensures that Mr. Smith has capacity when he issues instructions or designates an agent. Creating a well-thought-out written directive is not something Mr. Smith would do when he was hypomanic.

c. A Capacity Determination Requirement to Form Any Mental Health Directive Stigmatizes

States like Louisiana that require a physician attestation of patient capacity to form any mental health directive stigmatize people with mental illness. A sizable percentage of the American population has received treatment for mental illness. When free from the influence of an episode, many of these people are no less able to make rational treatment choices than people who do not have a mental illness. This is why the Commissioners’ decision to use the same definition of capacity for the physical and the mental health contexts makes sense. Moreover, unlike Louisiana, the Commissioners wisely decided to presume that all patients have capacity to form a directive. That presumption is appropriately rebuttable because some patients do not have capacity.

389 See supra notes 152-156 and accompanying text.
390 See supra note 5 and accompanying text.
391 Sheetz, supra note 6, at 401-403 (telling a story of a friend with bipolar disorder who befriended criminals when she was manic).
392 See supra note 370 and accompanying text.
393 Winick, supra note 130, at 57 (stating more than one in four Americans have been treated for mental illness in the previous year).
394 Sheetz, supra note 6, at 405.
395 UHCDA §1(3).
396 See supra note 370 and accompanying text.
397 UHCDA §11(b).
398 Id.
D. Activation

1. The Uniform Act's Patient Designated Activation

The Uniform Act chose patient designated activation which empowers individuals to determine the triggers which make their directives take effect.\(^{399}\) If the patient does not designate a different circumstance, the power of attorney for health care becomes effective when the primary physician determines the patient has lost capacity.\(^{400}\) The Uniform Act commentary uses the following example to illustrate patient designated activation.\(^{401}\) A mother may not want to continue to make her own health care decisions and may prefer that her daughter makes them for her.\(^{402}\) This mother may specify that her daughter should immediately have power of attorney, even before the mother becomes incapacitated.\(^{403}\) The mother retains the right to revoke the power of attorney at any time if she does so in writing.\(^{404}\)

2. Most States Do Not Empower Patients to Choose

The vast majority of states with separate mental health directive statutes do not allow directives to become active until the patient has lost capacity.\(^{405}\) However, some states empower a person to create a mental health directive which takes effect before loss of capacity.\(^{406}\) Even in these states, or under the Uniform Act, where patients may designate the activation standard,\(^{407}\) a patient with capacity may always override her directive or the decisions of her agent even after the directive has been activated.\(^{408}\)

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\(^{399}\) UHCDA §2(c,d) cmt.

\(^{400}\) Id.

\(^{401}\) Id. §2(c) cmt.

\(^{402}\) Id.

\(^{403}\) Id.

\(^{404}\) Id.

\(^{405}\) VHA Report, supra note 5, at 8 (stating in the remaining 19 states with separate statutes, directives don't become active until the patient loses capacity).


\(^{407}\) UHCDA §2(c & d).

\(^{408}\) VHA Report, supra note 5, at 8; UHCDA §2(c) cmt.
3. Analysis: Selecting the Appropriate Activation Standard

To choose the best activation standard, it is necessary to identify available options: (1) legal incompetence (used for guardianship proceedings), (2) decision-making capacity (used for informed consent), (3) dangerousness or severe disability (used for involuntary commitment), or (4) patient designated activation. Courts determine legal incompetence, but physicians determine incapacity. A legal incompetence activation standard does not empower patients to prevent devastation caused by mental illness for two reasons. First, a legal incompetence activation standard vests judges with the authority to determine when the directive becomes active even though judges have no specialized training in mental illness or in evaluating a patient's mental state. Second, the legal incompetence activation standard obstructs the patient's ability to obtain care. If a court determination is required before a directive becomes active, many patients will not be able to obtain intervention in time to prevent tragedy.

An involuntary commitment activation standard is even more problematic for patients attempting to obtain early intervention. For example, once Mr. Smith becomes hypomanic, he stops taking medication. As long as the episode induces him to refuse treatment, intervention will only occur when he meets strict criteria for involuntary hospitalization.

Because physicians, not courts, determine capacity, selecting incapacity as the default activation standard when patients fail to designate one better serves patients. Capacity should be the default activation standard because judges are less qualified than doctors to determine when a

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409 See supra Part I(D)(4).
410 See e.g., UHCDA §1(3).
411 See supra Part I(C)(1).
412 Sheetz, supra note 6, at 414-415; UHCDA §2.
413 Jessica Wilen Berg et al., Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions, 48 RUTGERS L. REV. 345, 348-49 (1996); Sheetz, supra note 6, at 415.
414 See infra notes 415 and accompanying text.
415 Sabatino, supra note 17, at 1245 (asserting the Commissioners wanted to keep most healthcare decisions out-of-court); Washington v. Harper, 494 U.S. 210, 231-32 (1990) (concluding that a person's interests are better served by allowing the decision to medicate to be made by a medical professional rather than an untrained judge).
416 See supra Part I(C)(1).
417 See supra Part I(C)(1).
418 See supra note 415.
patient is no longer able to make reasoned decisions about care.\footnote{UHCDAA §2.} Although requiring a physician capacity determination takes time, treatment delays are not as significant as delays caused by court hearings and rulings.

The Commissioners went a step further in empowering patients by allowing patients to determine activation standards, but the Commissioners should provide more guidance on directive activation in the mental health context.\footnote{UHCDAA §2(c & d).} Scholars contend activation before loss of capacity is important in the mental health context because early activation enables patients to prevent crisis.\footnote{J. Ritchie, R. Sklar, & W. Steiner, Advance Directives in Psychiatry: Resolving Issues of Autonomy and Competence, 21 INT. J. L. & PSYCHIATRY 245 (1998); G.N. Sales, The Health Care Proxy for Mental Illness: Can it Work and Should we Want it to? BULLL AM. ACAD. PSYCHIATRY L. 161 (1993); VHA Report, supra note 5, at 8.}

The following is an activation clause for Mr. Smith:

My bipolar disorder follows a pattern. Normally, I take my medication and remain stable. However, a stressful incident can make me lose sleep which causes me to become hypomanic. When I am hypomanic, I no longer recognize I need treatment and stop my medication. While I'm hypomanic, it is possible that my physician would determine I still technically possess capacity. Left untreated, my condition will deteriorate until I become psychotic.

This directive shall become active when my daughter and my brother execute a signed affidavit, listing the observed symptoms and attesting that they have concluded that I have become hypomanic. I have decided not to require a court determination of my incompetence or a physician's determination of my incapacity to activate this directive because such a requirement would delay treatment. During a manic episode, I will resist meeting with my psychiatrist and the court, further delaying treatment. I authorize early intervention when I am still approaching a crisis.

Mr. Smith recognizes that if he chooses incapacity, as determined by his psychiatrist as the activation standard, all of the following will have to take place before treatment. Someone will have to transport Mr. Smith to his psychiatrist. He will resist. Someone will have to make an appointment with his psychiatrist. Even if he obtains an appointment, when Mr. Smith is hypomanic, he does not want treatment. He will try to convince his psychiatrist of his capacity. Like most psychiatrists, Mr. Smith's psychiatrist
is not accustomed to working with directives and will be reluctant to
hospitalize Mr. Smith pursuant to the directive. Mr. Smith has listed two
people he trusts. He has required them to sign an affidavit attesting to their
observations. For him, this strikes the right balance between protection
against undue influence and obtaining early intervention. He should be free
to make this choice.

Mr. Smith's activation clause is an early activation clause because it
activates the directive before a physician has determined he has lost
capacity. Critics may argue early activation is problematic because it
creates potential for coercion. However, every patient should be free to
create an individualized plan. A patient concerned about family having
too much control can rely on the presumptive activation standard of a
physician determination of incapacity. Moreover, the Uniform Act and
states which allow early activation enable patients with capacity to override
their directives or the decisions of their agents even if the directives have
been activated. This is another reason the concern that early activation
exposes patients to undue risks of coercion is unjustified.

E. Advance Consent to Intrusive Treatments, the Role of Proxies, and
Patients who Fail to Plan

1. The Uniform Act Approach

Health care decisions of the guardian, agent, or surrogate are
effective without judicial approval. If neither the patient nor the court has
designated a proxy, or the proxy is unavailable, any available family
member may act as surrogate under a priority system starting with the
spouse. The surrogate must promptly inform the other family members of
her assumption of authority. Unless the person is related to the patient,
an owner, operator, or employee of a residential long-term health care
institution at which the patient receives care may not act as surrogate or

422 Supra note 335 and accompanying text.
423 VHA Report, supra note 5, at 8.
424 Sheetz, supra note 6, at 401.
425 UHCDCA §2(c, d) cmt.
426 VHA Report, supra note 6, at 8.
427 UHCDCA §2(f), 5(g), 6(c); see also §6(b) (stating decisions of agents take
precedence over decisions of guardians).
428 Id. §5(b) (setting priority as spouse, adult child, parent, adult sibling, then if
none of these are available, an adult who has exhibited special care and concern
and is familiar with the principal's values).
429 Id. §5(d).
agent. The patient may disqualify a person from acting as her surrogate by executing a signed writing or by informing her doctor. The Uniform Act imposes no other safeguards against the nomination of proxies who might depart from patient wishes.

If members of a class of surrogates who have equal priority (i.e. siblings) disagree about a treatment decision, majority rule applies. If these surrogates are still evenly divided, the decision-making process stops. It is time to seek a court-appointed guardian to make the decision. Agents and surrogates must make decisions in accordance with the patient's instructions or known wishes. If there are no instructions, agents and surrogates shall make decisions pursuant to the patient's best interests while considering the patient's values.

A patient can consent to mental health treatment in a directive by issuing instructions and/or designating a proxy. Whether a patient can grant a surrogate or agent the authority to consent to inpatient mental health treatment has been the subject of debate which was the impetus for the 1999 amendment to the Uniform Act. As amended, the Uniform Act now prohibits agents and surrogates from consenting to the patient's inpatient mental health treatment unless the written directive expressly provides such authority.

Despite the requirement for express written authorization for an agent or surrogate to consent to inpatient mental health treatment, the Uniform Act does not seem to require express written authorization for an agent or surrogate to consent to outpatient ECT or psychotropic medication. This is because the Uniform Act's broad grant of authority to

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430 Id. §5(i).
431 Id. §5(h).
432 See Stith, supra note 17, at 58 (asserting the Uniform Act fails to disqualify surrogates who might depart from patient values).
433 UHCDA §5(e) cmt.
434 Id.
435 Id. §5(e) cmt. & 14; see Sabatino, supra note 17, at 1249.
436 UHCDA §2(e), 5(f).
437 Id.
438 Id. §2.
439 Cohen, 760 N.E.2d at 613, 614, n. 13, 14; see also Winick, supra note 130, at 81-86.
440 UHCDA §13(e) & cmt. (clarifying the Uniform Act does not address whether a guardian has authority to consent to the principal's inpatient mental health treatment but leaving that matter to state guardianship law); see also §13(f) & cmt. (stating the Uniform Act does not affect mental health treatment of involuntarily committed people because state law addresses this matter).
441 UHCDA §1(6).
agents and surrogates includes the authority to make all health care decisions for the patient.\textsuperscript{442} Health care decisions include selection and discharge of doctors, approval and disapproval of tests, surgeries, medications, and orders to resuscitate, and directions to provide, withhold, or withdraw artificial nutrition, hydration, and other care.\textsuperscript{443} This definition appears broad enough to encompass ECT, psychotropic medication, and even psychosurgery.\textsuperscript{444} However, the Uniform Act and its commentary do not mention ECT, psychotropic medication, or psychosurgery.\textsuperscript{445} Rather, the enumerated examples of health care decisions focus on end-of-life decisions.\textsuperscript{446}

Clinicians and institutions must comply with a patient's instructions as well as a proxy's decisions.\textsuperscript{447} Decisions of agents, surrogates, and guardians obligate the clinician or institution to the same extent as the patient's instructions.\textsuperscript{448} There are limited exceptions to the mandate to adhere to the directive which are called override provisions.\textsuperscript{449} First, clinicians and institutions may refuse to implement instructions or a proxy's decisions for reasons of conscience.\textsuperscript{450} Institutions may only avoid their duties to follow the instruction or proxy's decision if it contravenes a policy based on conscience.\textsuperscript{451} Second, clinicians and institutions may refuse to implement instructions or a proxy's decisions requiring medically ineffective care or treatment contrary to accepted standards.\textsuperscript{452} To avoid the obligation to implement an instruction or proxy decision, the clinician or institution must inform the authorized decision-maker, and if possible, the patient, assist in transferring the patient to another facility willing to

\begin{enumerate}
\item \textit{Id.} §1(6), 2(b), 5(a).
\item \textit{Id.} §1(6).
\item \textit{Id.}
\item UHCDA.
\item \textit{Id.} §1(6).
\item \textit{Id.} §7(d).
\item \textit{Id.}
\item \textit{Id.} §7(e-f); VHA Report, supra note 5, at 6 (asserting 17 states give clinicians more leeway to avoid following a mental health directive than they do for general directives and concluding this undermines patient autonomy and illustrates mental health "exceptionalism"); \textit{Hargrave v. Vermont}, 340 F.3d 27 (2d Cir. 2003) (holding that a Vermont statute authorizing overriding durable powers of attorney for health care only for persons civilly committed or adjudged mentally ill, in order to involuntarily medicate such patients, discriminated against people with mental illness on the basis of their disability, within the meaning of Title II of the Americans with Disabilities Act and the Rehabilitation Act).
\item UHCDA §7(e).
\item \textit{Id.} §7.
\item \textit{Id.} §7(f).
\end{enumerate}
implement the instruction or proxy decision, and provide care until transfer.\textsuperscript{453}

2. State Approaches

Whereas the Uniform Act only removes from the potential agent and surrogate pool people affiliated with a residential long-term health care institution where the patient receives care,\textsuperscript{454} most states provide broader protection against health care fraud by removing people affiliated with any facility treating the patient.\textsuperscript{455} Some states that have implemented the Uniform Act have amended the Uniform Act's automatic surrogate selection priority system to safeguard against selecting a surrogate who might depart from patient values.\textsuperscript{456} For example, Delaware disqualifies a spouse when there has been a complaint of domestic abuse.\textsuperscript{457} Hawaii refused to enact the priority list and selects surrogates based on consensus of interested parties.\textsuperscript{458}

Whether a principal can convey authority to an agent to consent to the principal's admission in a mental health facility depends on where the principal lives.\textsuperscript{459} Some states authorize patients to create mental health directives but do not allow patients to empower an agent to consent to inpatient mental health treatment.\textsuperscript{460} North Dakota enables a patient to convey an agent authority to consent to voluntary commitment of the patient for up to forty-five days but prohibits the patient from consenting to commitment for any greater length of time.\textsuperscript{461} Other states follow the Uniform Act approach by allowing an agent to consent to the principal's inpatient treatment only with express authority in a written directive.\textsuperscript{462}

\begin{footnotesize}
\begin{enumerate}
\item Id. §7(g).
\item UHCD \textsuperscript{a} §5(i).
\item See e.g., CAL. \textsuperscript{c} PROB. CODE §4659(a-b) (2002); ALASKA STAT. §13.50 2.010(c) (2006).
\item Stith, \textit{supra} note 17, at 58.
\item DEL. \textsuperscript{d} CODE tit. 16, §2507(b)(2)(f) (amended 2004).
\item Stith, \textit{supra} note 17, at 58.
\item See \textit{infra} notes 460-463 and accompanying text.
\item Cohen v. Bolduc, 760 N.E.2d 714, 718 n. 15 (2002); \textit{see e.g.}, CAL. \textsuperscript{e} PROB. CODE §4252 (West Supp. 2001); TEX. \textit{h} HEALTH \& \textit{i} SAFETY CODE ANN. §166.152(f)(1) (West 2001); WIS. \textsuperscript{f} STAT. ANN. §155.20 (2) (West Supp. 2000).
\item N.D. \textsuperscript{f} CENT. CODE §23-06-5-03 (Lexis Nexis Supp. 2001); \textit{Cohen}, 760 N.E.2d at 718 n. 15.
\item \textit{Cohen}, 760 N.E.2d at 719, n. 17; \textit{see e.g.}, MISS. \textsuperscript{g} CODE ANN. §41-41-227(5) (Lexis Nexis 2001); ARIZ. \textsuperscript{h} REV. STAT. §36-3283(f) (West Supp. 2000); HAW. \textsuperscript{i} REV. STAT. §327E-13(e) (Supp. 2000); FLA. \textsuperscript{k} STAT. ANN. §765.113(1) (West 1997); OKL. \textsuperscript{l} ST. ANN. §11-106(C)(2) (1995).
\end{enumerate}
\end{footnotesize}
Finally, some states allow an agent to consent to the principal's inpatient mental health treatment even without express commitment authority as long as the grant of authority is sufficiently broad.463

Whether a patient may use a directive to consent to intrusive treatments also depends on where she lives.464 Many states prohibit patients from consenting to or conveying authority to an agent to consent to psychosurgery in a directive.465 Several states do not empower a principal to convey authority, even expressly, to an agent to consent to the principal's ECT; a court order is required.466 Kentucky empowers patients to issue binding refusals of treatments but, arguably, does not empower patients to issue binding consents.467 This is because Kentucky explicitly authorizes patients to use directives to refuse specific medications or ECT but only to state preferences for medications or emergency interventions.468 This language suggests doctors are bound to adhere to the patient's refusals and must consider patient medication preferences but are not required to administer those medications.469 Finally, some states empower a principal to use a directive to consent to and convey authority to an agent to consent to intrusive treatments, including ECT470 and psychotropic medication.471

463 See e.g., Cohen 760 N.E.2d at 723 (stating Massachusetts allows an agent to commit a principal even without express written commitment authority).
464 See infra notes 465-471 and accompanying text.
465 See e.g., CAL. PROB. CODE §4652 (West Supp. 2001); WASH. STAT. §11.92.043 (prohibiting a guardian from consenting to surgery solely for the purpose of psychosurgery); OR. REV. STAT. §127.540 (1999); TEX. HEALTH & SAFETY CODE ANN. §166.152 (West 2001).
466 See Jorgensen, supra note 56, at 1 (stating many states require proxies to obtain prior court authorization before consenting to ECT on behalf of an incapacitated ward); see e.g., N.H. REV. STAT. §464-A: 25; OR. REV. ST. §127.540 (1999); CAL. PROB. CODE §4652 (West Supp. 2001); TEX. HEALTH & SAFETY CODE ANN. §166.152(f); DC STAT. §7-1231.07(e) (2001).
467 See Sheetz, supra note 6, at 425; KY. REV. STAT. §202A .422 (Lexis Nexis 2003)
468 Id.
469 Id.
470 ECT is more regulated than psychotropic medication. See, Jorgensen, supra note 56, at Appen. A (providing a table state statutes concerning ECT); see e.g., WASH. REV. STAT. §§71.32.260, 71.32.160 (allowing principal to indicate whether she consents and authorizes her agent to consent to administration of ECT); M.C.L.A. §330.1717 (prohibiting administration of ECT without consent from the patient, the guardian, or the agent if the directive grants the agent authority to consent to ECT).
471 See e.g., WASH. REV. STAT. §§71.32.100, 71.32.050, 71.32.260; Minn. Stat. §253B.03(6)(d) (1991) (authorizing a patient to make a declaration consenting to...
3. Analysis

a. The Uniform Act Limitation on Who May Serve as Proxy Provides Insufficient Protection

There is evidence that health care fraud is more pervasive in the mental health sector. Therefore, patients with mental illness are more vulnerable than other patients to receiving treatment they do not need or to which they have not consented. A person who has a financial incentive in administering treatment should not serve as the patient's agent, unless she is a family member. The Uniform Act only prohibits owners, operators, and employees of residential long-term health care institutions (who are not relatives) where the patient receives care from being the patient's agent or surrogate. The Commissioners recognized that patients in nursing homes are particularly vulnerable. However, most patients receive mental health care outside of long-term residential health care institutions. The Uniform Act limitation of the potential agent and surrogate pool does not protect patients with mental illness. Unless the person is related to the principal, no owner, operator, employee, or agent of any facility where the principal receives care should act as agent or surrogate.

b. The Uniform Act's Lack of Guidance on Mental Health Treatments Combined with Broad Authority to Automatically Selected Surrogates Poses Undue Risks

Although the Uniform Act's definition of health care decisions appears broad enough to encompass ECT, psychotropic medication, or even psychosurgery, the Uniform Act and its commentary never specifically address any of these intrusive treatments. This vacuum of guidance combined with the Uniform Act's broad grant of authority to surrogates the

or refusing intrusive mental health treatments and to convey authority to an agent to make decisions about intrusive mental health treatments); Ind. Code §16-36-1.7-3 (authorizing a patient to specify in a directive psychotropic medication, electroconvulsive therapy, and inpatient treatment); N.C.G.S.A. §122C-73 (1997) (allowing use of a directive to grant or withhold authority for psychotropic medication, electroconvulsive therapy, and inpatient mental health treatment).

See supra note 386 and accompanying text.

UHCDA §5(i).

Sabatino, supra note 17, at 1243-44.

Id.

UHCDA §1(6).
principal never choseposes undue risks of coercion and undue influence as illustrated by the following hypothetical.

Ms. Jones has endured a tumultuous marriage. In the past, Ms. Jones alleged that Mr. Jones abused her. She voluntarily admits herself in the psychiatric ward because she is severely depressed. After admission, her depression becomes laced with delusions. Her psychiatrist determines that she has lost capacity. She has no guardian, agent, or directive. In the past, Ms. Jones has taken medication to treat her mental illness. She has never expressed any opinion about ECT. Mr. Jones notifies her psychiatrist and family that he will serve as her surrogate. The psychiatrist explains treatment options to Mr. Jones which include outpatient ECT. Mr. Jones selects ECT to treat his wife. Her siblings and parents disagree. Although they have never discussed ECT with Ms. Jones, they believe she would not want to receive it. They also do not trust Mr. Jones. Nonetheless, Mr. Jones exercises his authority as surrogate and authorizes ECT.

Unless administering ECT violates the doctor's conscience, the hospital's policy, or is an ineffective treatment (making the Uniform Act override provision apply), her doctor must comply with his decision and administer outpatient ECT. Most likely, none of these narrow exemptions apply to ECT, which, despite its side effects, is widely recognized as an effective treatment. Even if the doctor refuses to administer ECT under one of the exemptions, the doctor must ensure the transfer of Ms. Jones to a facility willing to administer ECT. The Uniform Act requirement for Ms. Jones's express written authorization to enable a proxy to consent to her inpatient mental health treatment does not limit Mr. Jones's power to consent to his wife's outpatient ECT.

Although Mr. Jones must have express authority to consent to his wife's inpatient mental health treatment, the Commissioners failed to impose such a requirement on outpatient psychotropic medication, ECT, or psychosurgery. Because Ms. Jones left no instructions, Mr. Jones is supposed to make her health care decisions based on his estimation of what is in her best interests. Based on their history, it is quite possible that he would not make decisions in her best interests. Invoking one of the few Uniform Act safeguards, one of Ms. Jones's family members may petition

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477 Id. §5(a).
478 Id. §7(d-f).
479 See infra Part I(B)(2).
480 UHCDA §7(g).
481 Id. §13(e) & cmt.
482 UHCDA §13(e).
483 UHCDA § 5(f).
the court for an injunction to stop administration of ECT.\textsuperscript{484} However, if no family member cares enough to do so or if the family member does not prevail, Mr. Jones's decision controls. The history of domestic violence does not limit his power to make health care decisions for Ms. Jones because the Commissioners neglected to remove from the surrogate pool family members who might depart from patient values.\textsuperscript{485} Neither Ms. Jones nor a court evaluated whether Mr. Jones could be trusted to make decisions in line with his wife's values. Most likely, Ms. Jones would not have chosen Mr. Jones.

It is appropriate for the Uniform Act to create a decision-making framework for the vast majority of the population who fails to plan for end-of-life care.\textsuperscript{486} Turning to family makes sense.\textsuperscript{487} However, one size does not fit all. In the mental health context, arbitrarily selecting a spouse to be surrogate because he is first in line undermines patient autonomy. The Uniform Act's grant of unchecked authority to a single family member whom the patient never chose ignores the realities of mental illness which often devastates familial relationships, especially marriages.\textsuperscript{488} Even in the absence of domestic abuse, many patients would not want their spouses, acting alone, without court approval, to have the power to authorize ECT, psychotropic medication, or psychosurgery. For example, during manic episodes, Mr. Smith verbally attacked his wife. Most likely, she would have authorized any treatment, including ECT, to control Mr. Smith's mania, even if Mr. Smith would not have consented to ECT. The Uniform Act automatically designates the spouse as surrogate.\textsuperscript{489} However, many people with mental illness recognize that they offend their spouses during acute episodes and would not convey to their spouses authority to authorize intrusive treatments.

\textsuperscript{484} UHCDA §14.
\textsuperscript{485} Stith, \textit{supra} note 17, at 57-58.
\textsuperscript{486} See Sabatino, \textit{supra} note 17, at 1248-1249 (asserting that automatic designation of surrogates is the most common situation because few patients have directives).
\textsuperscript{487} FURROW, \textit{supra} note 151, at 849 (citing a 1983 Report from the President's Commission for the Study of Ethical Problems in Medicine for the proposition that turning to an incompetent patient's family to make the patient's health care decisions make sense because: (1) family is generally most concerned about the patient; (2) family will be most knowledgeable about the patient's values; (3) family deserves recognition as an important social unit; and (4) the state should be reluctant to intrude into personal family matters).
\textsuperscript{488} Davoli, \textit{supra} note 5, at 1045 (recommending early intervention before the mental illness erodes the patient's support system).
\textsuperscript{489} UHCDA §5(b).
c. When a Patient Selects an Agent, Requiring Express Authority to Authorize Inpatient Treatment is an Undue Burden

The Uniform Act’s failure to remove from the surrogate pool individuals who might depart from patient values undermines patient autonomy and risks coercion and undue influence.490 When a surrogate is automatically selected, the patient has no input. Providing broad authority to an agent the patient selected is less problematic. The patient maintains influence over her care.491 When the patient has capacity, she can communicate her preferences to her agent. She can select an agent she trusts to make decisions consistent with her values. However, the Uniform Act unjustifiably limits a patient’s right to authorize an agent to consent to inpatient mental health treatment.492 The Act prohibits an agent from consenting to the principal's admission to a mental health care institution unless the principal's written directive expressly provides such authority.493 Cohen v. Bolduc underscores the reasons why this arbitrary limitation undermines patient autonomy.494

In Cohen v. Bolduc, the Massachusetts Supreme Court analyzed whether Massachusetts’ general health care proxy statute authorized an agent to commit a principal to a mental health facility when the principal did not oppose.495 The principal’s health care proxy stated: "My health care agent is granted full power and authority to consent to any and all medical treatment which I may need in the event that I am unable to consent… including, without limitation, authority to consent to medical care, hospitalization, nursing home admission, or whatever else may in my health care agent's sole judgment is in my best interest... I further state... that there are no limitations imposed upon my health care agent's authority."496

The proxy was activated when Bolduc’s psychiatrist decided Bolduc lacked capacity.497 Bolduc suffered from auditory hallucinations and paranoid and psychotic thoughts.498 Bolduc’s psychiatrist admitted Bolduc into a mental health facility under Massachusetts’ emergency psychiatric

490 See Stith, supra note 17, at 57-58 (exploring these risks in the end-of-life care context).
491 See Winick, supra note 130, at 82-85.
492 UHCDA §13(e).
493 Id.
494 Cohen, 760 N.E.2d at 720-724.
495 Id. at 715.
496 Id.
497 Id. at 716.
498 Id.
hospitalization procedures. Bolduc's agent then converted Bolduc's admission status to conditional voluntary, a status which imposed no temporal limits on Bolduc's hospitalization. Had her agent not done so, Massachusetts law would have required the hospital to file a petition to retain Bolduc involuntarily which would have required proof that Bolduc met strict involuntary commitment criteria.

Later, Bolduc revoked her proxy and demanded discharge from the hospital. The hospital then filed a petition to retain Bolduc involuntarily within the statutory timeframe if that deadline accrued from the date of Bolduc's proxy revocation. However, Bolduc moved to dismiss the hospital's petition on the grounds that it was not timely filed, arguing that the ten-day timeline accrued from an earlier date because her daughter never had authority to convert her status to conditional voluntary.

The Massachusetts statute did not address whether the principal's grant of unlimited decision-making authority conveyed to the agent the authority to consent to the principal's inpatient mental health treatment. However, the proxy statute granted an agent the authority to make any health care decisions for the principal and defined "health care" broadly to include treatment of "mental conditions." According to Cohen, the statute left no indication that the legislature intended to limit an agent's authority regarding particular areas of treatment.

Cohen concluded that the statutory language suggested that agents had the authority to commit the principal to a mental health facility.

Cohen also considered the policy implications and wisely determined that prohibiting an agent from committing her principal frustrated the purpose of the proxy statute to support patient autonomy. Under the statute, the agent's decisions had the same effect as the principal's decisions. Cohen correctly stated that restricting the range of advance planning choices unduly limited the principal's ability to control her own
care. The Cohen Court departed from the Uniform Act because the Court did not require express authority in a written directive to empower the agent to commit the principal. The principal's grant of unlimited authority to make health care decisions was sufficient.

For a directive to be an effective tool, a patient must be able to use her directive to consent to mental health treatments and empower an agent to do the same. The Uniform Act's requirement for express authority in a written directive for an agent to consent to inpatient mental health treatment undermines patient autonomy for the following reasons.

First, arbitrary limitations on an agent's ability to consent to the principal's treatment will result in principals not receiving care they need and to which they consented. The Uniform Act requires the principal to appreciate that she must use magic words conveying authority to an agent to consent to her admission in a mental health institution. It is illogical that Bolduc's written grant of unlimited authority to make health care decisions to her daughter would not include the right to consent to admission in a mental health facility. However, had the Massachusetts Supreme Court applied the Uniform Act, this would have been the illogical result. Patients who grant unlimited authority to agents have the right to expect that doctors and agents will look to the patient's own words to determine the scope of the agent's authority.

Second, limiting a patient's right to consent in advance to inpatient and pharmacological mental health treatment imposes a unique burden on patients with mental illness who have been historically stigmatized. States provide patients the authority to refuse life-sustaining treatment, either through instructions or through agents. The U.S. Supreme Court has recognized that the right of patient autonomy can outweigh the significant state interest in preservation of life. No state interest in preserving life is implicated when a patient grants an agent authority to consent to

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511 Id.
512 Id. at 715.
513 Id.
514 UHCDA §13(e) & cmt.
515 UHCDA §13(e) & cmt.
516 Cohen, 760 N.E.2d at 715.
517 UHCDA §13(e) & cmt.
518 See supra notes 269-274 and accompanying text; FURROW et. al, supra note 151, at 831-835 (asserting that whether the right to forego life-sustaining treatment is based on the U.S. Constitution, state constitution, statute, or state common law, the right is not absolute but may be limited and in rare cases outweighed by other interests).
519 See supra notes 204-217 and accompanying text.
psychotropic medication and inpatient mental health treatment. On the other hand, there is a tremendous patient interest in securing treatment to prevent a crisis.

However, ECT is a unique, invasive treatment.\(^{520}\) The Uniform Act fails to mention ECT and can be construed to authorize a surrogate the patient never selected to consent to the patient's outpatient ECT.\(^{521}\) Moreover, under the Uniform Act, a patient who conveys broad decision-making authority but never mentions ECT arguably conveys authority to an agent to authorize the patient's ECT.\(^{522}\) ECT is more invasive and controversial than pharmacological therapy.\(^{523}\) It is for this reason that many states prohibit an agent from consenting to ECT without a court order.\(^{524}\) Because ECT is an effective treatment for many patients, patients should be able to consent to and convey authority to an agent to consent to the patient's ECT.\(^{525}\) Considering the invasive nature of ECT, advance consent to ECT should have to be express.

d. The Uniform Act Can Be Interpreted to Authorize a Proxy to Consent to Psychosurgery

The Uniform Act grants to agents, surrogates, and guardians the authority to make all health care decisions for the principal when the principal lacks capacity.\(^{526}\) This authority is unchecked because no court approval is necessary.\(^{527}\) The broad health care decision definition could be interpreted to include psychosurgery, a rarely used treatment of last resort.\(^{528}\) The Uniform Act's enumerated examples of health care decisions focus on end-of-life decisions and do not mention psychosurgery.\(^{529}\) On its face, the broad health care decision definition appears to include psychosurgery.\(^{530}\) Such an interpretation potentially empowers a surrogate or agent, without the principal's express authority, to consent to the

\(^{520}\) See supra notes 56-64 and accompanying text.
\(^{521}\) UHCD A §1(6).
\(^{522}\) UHCD A §§2(b), 1(6).
\(^{523}\) See supra notes 60, 466 and accompanying text.
\(^{524}\) See supra note 466 and accompanying text.
\(^{525}\) See supra notes 61-62 and accompanying text.
\(^{526}\) UHCD A § 1(6).
\(^{527}\) Id. §2(f), 5(g), 6(c).
\(^{528}\) Id. §1(6).
\(^{529}\) Id. (listing orders not to resuscitate and directions to provide, withhold, or withdraw artificial nutrition and hydration as examples of health care decisions).
\(^{530}\) Id. (including approval and disapproval of surgical procedures in the health care decision definition).
principal's psychosurgery.\footnote{13}{Id. §13(e) & cmt. (If the surgery was performed inpatient, the Uniform Act would require the principal's express authorization in a written directive for the agent or surrogate to consent to admission. However, the Uniform Act fails to address whether such express authority would be necessary for the agent to consent to the psychosurgery itself).} Granting a proxy this authority is unwise which may be why many states prohibit a proxy from consenting to the principal's psychosurgery.\footnote{14}{See supra note 465 and accompanying text.} Instead, doctors can use other, less intrusive treatments to restore the patient's capacity. Then, with full capacity, the patient can decide whether to consent to psychosurgery.

\section*{F. Directive Templates}

1. The Uniform Act Template

The Uniform Act provides a model statutory form which allows principals to designate agents and provide instructions.\footnote{15}{UHCDA §4.} Principals may check boxes to indicate whether they want to prolong life as long as possible.\footnote{16}{Id.} One section of the form allows the principal to indicate whether she wants artificial nutrition and hydration withheld and whether she wants to donate her organs.\footnote{17}{Id.}

2. Analysis: Offer a Template?

Not only does the Uniform Act template fail to address basic mental health issues,\footnote{18}{UHCDA §4.} showing this form at the wrong time to already vulnerable patients could be confusing and unsettling. One commentator noted that some hospitals are reluctant to provide patients with templates that ask for instructions about harvesting organs because it gives the wrong impression at the wrong time.\footnote{19}{Sabatino, supra note 17, at 1248.} Mr. Smith recently suffered a psychotic episode. He is now stable but vulnerable. He wants to create a directive to prevent future devastation. This is not the time for Mr. Smith, a recently traumatized but otherwise healthy man, to ponder whether he wants to donate his organs. Thinking about end-of-life issues distracts Mr. Smith from the mental health issues he confronts and could deter him from creating a directive.
The drawbacks of providing a model form outweigh the benefits.\textsuperscript{538} One scholar observed that "statutory forms tend to become fixed realities with a life of their own that is resistant to change."\textsuperscript{539} Patients with bipolar disorder, depression, schizophrenia, drug addiction, or various other mental illnesses\textsuperscript{540} may elect to create mental health directives. Even patients diagnosed with one mental illness, such as bipolar disorder, will present in different ways and experience different levels of severity of the illness.\textsuperscript{541} A single template cannot address the unique needs of the varied patient population. Psychiatrists should encourage patients to create their own directives tailored to their individual needs. There is a danger that a statutory form will become the standard from which patients are afraid to deviate.\textsuperscript{542}

III. SOLUTION: ISSUE A MODEL STATUTE

This Part recommends the Commissioners adopt a model mental health directive statute because the Uniform Act fails people with mental illness. The Uniform Law Commission is the appropriate organization to issue a model statute because uniformity benefits patients. State advance directive statutes vary widely, and key provisions in several state statutes do not meet the needs of patients with mental illness.\textsuperscript{543} A person's ability to control her illness should not depend on the state in which she lives. Moreover, patients frequently receive care for acute episodes away from their hometowns. Uniform direction from the Commissioners helps ensure that a patient's directive is valid wherever she receives care. Appendix A contains model statutory provisions.

The model legislative findings recognize that issues implicated in end-of-life care are different from issues confronting patients with mental illness and explain the need for Ulysses arrangements. The model procedures for implementing Ulysses arrangements are this Article's greatest contributions to patient empowerment. The Uniform Act and even Washington prevent people from forming Ulysses arrangements.\textsuperscript{544}


\textsuperscript{539} Sabatino, supra note 17, at 1248.

\textsuperscript{540} DSM-IV TR, supra note 8, at 297-344 (schizophrenia), 345-428 (mood disorders), 191-296 (substance related disorders).

\textsuperscript{541} DSM-IV TR, supra note 8, at 345-429.

\textsuperscript{542} See Sabatino, supra note 17, at 1248.

\textsuperscript{543} See supra Parts II(B) (2), (C)(3)(c), (D)(2).

\textsuperscript{544} WASH. REV. CODE §71.32.140(6)(b).
model provision empowers patients to receive three weeks of inpatient mental health care pursuant to their irrevocable directives despite illness induced refusals. Recognizing the sensitivities of administering treatment despite illness induced refusals, the model provisions create safeguards. First, patients who enter Ulysses arrangements must obtain a clinician attestation of patient capacity. Second, if an incapacitated principal with a Ulysses arrangement refuses psychotropic medication, only licensed psychiatrists may administer the medication, only if the directive expressly consents to psychotropic medication, and two psychiatrists recommend the specific medication.

The model language also adopts other safeguards from Washington such as the requirement for timely capacity evaluation and provisions allowing patients to seek injunctive relief. However, the model language better enables patients to control their illnesses than Washington does. First, the model language eliminates the Washington requirement for discharge of an incapacitated patient who demands discharge even if discharge contravenes her irrevocable directive. Second, unlike Washington, the model language creates a rebuttable presumption of incapacity when a patient's irrevocable directive consents to treatment the patient then refuses under the spell of her illness. This rebuttable presumption recognizes doctors will be reluctant to treat when faced with the patient's illness induced refusals and will likely adjudge patients as having capacity. Such "caution" prevents intervention which could stave off a crisis. Discharging a patient in contravention of a directive ignores the voice of the patient when she was free from the irrational influence of the Sirens' song. The rebuttable incapacity presumption encourages doctors to follow the directive and treat the patient. Moreover, many states do not allow patients to revoke mental health directives while incapacitated. The model language empowers patients to choose whether to make their directives revocable during periods of incapacity.

The Uniform Act's elimination of the requirement for a signed, witnessed writing removes protections for patients who are vulnerable to undue influence, coercion, and fraud. However, some states go too far and create obstacles to directive formation that further stigmatize mental illness, such as requiring a capacity determination to create any mental

545 Id. §71.32.140(2)(a), (4)(b).
546 Id. §71.32.140(6)(b).
547 See supra Part II(B)(3).
548 See supra Part II(B)(4)(a).
549 See supra Part II(B)(2).
550 UHCDA §2(a), 5(a).
health directive. The model language strikes the right balance. There are no unnecessary obstacles to directive formation. Patients need only obtain a capacity determination if they form a Ulysses arrangement. While removing unnecessary formalities, the model provision contains safeguards the Uniform Act eliminates such as the requirement of a signed, writing witnessed by two people who do not have conflicts of interest and attest that the principal presented identification and did not appear coerced.

The model activation provision provides guidance the Uniform Act fails to give on how patient designated activation works in the mental health context. Many state mental health directive statutes do not allow patients to determine the standard by which their directives become active. Postponing activation until the point at which a physician determines the patient has lost capacity delays care. The model activation provision facilitates early intervention and protects against coercion by clarifying that a directive does not prevail over contemporaneous preferences of a principal with capacity.

The model provisions concerning agents and the permissible scope of directives address important issues the Uniform Act, with its focus on end-of-life, either fails to address or addresses in a way which works poorly in the mental health context. First, unlike the Uniform Act which only excludes from the agent/surrogate pool people affiliated with long term residential facilities, the model language focuses on mental health. Many people receive mental health treatment outside nursing homes. To protect against health care fraud, which is more common in the mental health sector, the model language removes from the potential agent pool people affiliated with any facility treating the patient.

Second, unlike the Uniform Act which fails to mention ECT, psychotropic medication, or psychosurgery, the model provisions explicitly authorize principals to issue instructions or appoint agents to consent to or refuse ECT, psychotropic medication, and inpatient treatment. The model provisions prohibit a directive from authorizing psychosurgery, a controversial and rarely used treatment. The Uniform Act's lack of guidance on intrusive mental health treatments combined with broad

551 See supra note 370 and accompanying text.
552 See supra Part II(D)(2).
553 See supra Part II(D)(3).
554 See e.g., supra Part II(B)(1).
555 UHCDA §2(b), 5(i).
556 See supra note 386 and accompanying text.
557 UHCDA §1(6)
558 See supra Part I(B)(3).
authority granted to surrogates the principal never selected\textsuperscript{559} poses undue risks of coercion. In the model statute, the Commissioners should eliminate provisions for automatic surrogate selection. People whom neither the principal nor the court selected should not have the power to authorize intrusive mental health treatments.

However, even when a principal selects an agent, the Uniform Act imposes the arbitrary requirement for express authority in a written directive for the agent to authorize admission in a mental health facility.\textsuperscript{560} This burden undermines patient self-determination and could deprive people of care they need and to which they consented.\textsuperscript{561} Under the model provisions, the plain language of the principal's written grant of authority determines the scope of the agent's authority to consent to inpatient mental health treatment and/or psychotropic medication for the principal. This meets the expectations of a principal who grants unlimited authority to an agent to make her health care decisions.\textsuperscript{562} However, because ECT is more controversial and invasive than pharmacological therapy, the model language protects patients by forbidding an agent from consenting to the principal's ECT unless the principal's directive expressly grants such authority.

Finally, instead of a template,\textsuperscript{563} the Commissioners should provide a sample of a fictional patient's directive. The sample should be a Ulysses arrangement which consents to intrusive treatments and designates an agent.\textsuperscript{564} Patients would recognize that they need not adopt the directive but that the directive is an example tailored to the needs of one patient.\textsuperscript{565}

CONCLUSION

As part of his plan to protect communities from gun violence, President Obama wants to improve mental health services. Ulysses arrangements increase access to mental health care because they enable people to obtain intervention when an acute episode prevents them from recognizing they need treatment. The Uniform Act purports to be a

\textsuperscript{559} UHCDA §5(a).
\textsuperscript{560} UHCDA §13(e) & cmt.
\textsuperscript{561} \textit{See supra} Part II(E)(3)(c); \textit{see also} Cohen, 760 N.E.2d at 722.
\textsuperscript{562} UHCDA §13(e) & cmt.
\textsuperscript{563} UHCDA §4.
\textsuperscript{564} In this way, the sample would illustrate how one patient crafted a directive to ensure he received treatment during a crisis, despite his illness induced refusals.
\textsuperscript{565} \textit{See} Sabatino, \textit{supra} note 17, at 1247 (asserting the Commissioners' goals of comprehensiveness and simplicity met their toughest test when the Commissioners created a model form because directives often need to provide great detail).
comprehensive model advance directive statute which addresses all types of advance health care planning, but it fails to meet the needs of people with mental illness. The Uniform Act's most significant shortcoming is that it prevents patients from forming Ulysses arrangements. Washington's approach is touted as being at the forefront of patient empowerment. However, even Washington prohibits Ulysses arrangements by requiring discharge of an incapacitated patient who demands discharge even when releasing the patient contravenes her irrevocable directive.

The Commissioners should issue a model statute which empowers patients to enter Ulysses arrangements, removes roadblocks to directive formation, creates parity for mental health care, prevents fraud, coercion, and undue influence, and reduces the stigma of mental illness. The recommended provisions accomplish these goals. Unlike Washington, the model language does not require doctors to heed a patient's illness induced discharge demands which are in contravention of her directive. Also unlike Washington, the model language creates a rebuttable presumption of incapacity when the patient's irrevocable directive consents to treatment the patient then refuses under the spell of an episode. This presumption facilitates treatment because it recognizes doctors will be reluctant to treat a patient in the face of illness induced refusals. If the Commissioners adopt this model statute and states follow suit, people like Mr. Smith will have the power to seize control of their illnesses and prevent tragedy.

* * *

APPENDIX A

Legislative Findings

(1) Issues implicated in advance planning for end-of-life care are distinct from issues implicated in advance planning for mental health care.
(2) An individual with capacity has the right to control decisions relating to her mental health care.

566 See supra notes 269-274 and accompanying text.
567 UHCDA §3.
568 WASH. REV. CODE §71.32.140; see Sheetz, supra note 6, at 401, 433.
569 WASH. REV. CODE §71.32.140(6)(b).
570 Id. §71.32.140(6)(b).
571 Id. §71.32.140(2)(a).
572 See supra Part II(B)(4).
573 See WASH. REV. CODE §71.32.010 which inspired the model findings which emphasize Ulysses arrangements more than Washington does.
Mental illness is often episodic. Periods of incapacity obstruct the individual's ability to give informed consent and impede the individual's access to mental health care.

Facilitating advance planning helps: (a) prevent unnecessary involuntary commitment and incarceration, (b) improve patient safety and health, and (c) improve care and enable patients to exercise control over their treatment.

An acute episode can induce an individual to refuse treatment when the individual would consent to treatment if the individual's judgment were unimpaired. Empowering people to create self-binding mental health advance directives ("directives") to overcome their illness induced treatment refusals protects patient safety, autonomy, and health.

Individuals with mental illness have the same rights to plan in advance for treatment as individuals planning for end-of-life care. A directive can only accomplish the goals listed above if a patient may use a directive to:

(a) Set forth instructions for mental health care, including consent to inpatient mental health treatment, psychotropic medication, or electroconvulsive therapy;
(b) Dictate whether the directive is revocable during periods of incapacity and consent to treatment despite illness induced refusals;
(c) Choose the standard by which the directive becomes active; and
(d) Designate an agent to make health care decisions for the patient.

Execution of Directives

A directive shall:

(1) Be in writing;
(2) Be dated and signed by the principal or the principal's designated representative if the principal is unable to sign;
(3) State whether the principal wishes to be able to revoke the directive at any time or whether the directive remains irrevocable during periods of incapacity. Failure to clarify whether the directive is revocable does not render it unenforceable. If the directive fails to state whether it is revocable, the principal may revoke it at any time.
(4) Contain a principal affirmation that the principal is aware of the nature of the document signed and signed the directive freely and voluntarily;
(5) Be witnessed in writing by at least two adults. No witness may be:

574 See WASH. REV. CODE §§71.32.050, 71.32.060, 71.32.090 which inspired this provision, but, unlike Washington, this provision requires a mental health professional attestation of principal capacity to form a Ulysses arrangement and allows principals who fail to address revocation to freely revoke. See §71.32.070.

(a) A member of the principal's treatment team;
(b) Related to the principal by blood, adoption, or marriage;
(c) Be in a romantic or dating relationship with the principal;
(d) The agent of the principal or a person designated to make health care decisions for the principal; or
(e) The owner, operator, employee, or relative of an owner or operator of a treatment facility in which the principal is a patient.

(6) Witnesses shall attest:
(a) They were present when the principal signed the directive;
(b) The principal did not appear incapacitated or under undue influence or duress when the principal signed the directive; and
(c) The principal presented identification or the witness personally knows the principal.

(7) Contain a written, signed attestation from a mental health professional that the principal had capacity at the time of directive execution only if the principal makes the directive irrevocable. If the principal is free to revoke the directive at any time, no mental health professional attestation of principal capacity is required.

(8) Be valid upon execution.

Activation of Directives

(1) Activation is the point at which the directive is used as the basis of decision-making and dictates treatment of the principal. 576

(2) Unless the principal otherwise designates in the directive, a directive becomes active when the principal loses capacity.

(3) The principal may designate an activation standard other than incapacity by describing the circumstances under which the directive becomes active.

(4) Despite activation, a directive does not prevail over contemporaneous preferences expressed by a principal who has capacity.

Role of Agents 577

(1) In a directive, a principal may appoint an agent to make all health care decisions for the principal, including decisions to consent on behalf of the principal to electroconvulsive therapy, inpatient mental health treatment, and psychotropic medication.

(2) Express authorization to the agent to consent to the principal's inpatient mental health treatment and/or psychotropic medication is not required to convey authority to an agent to consent to such treatments.

576 VHA Report, supra note 5, at 8.
577 See WASH. REV. CODE §71.32.100 which inspired this provision, but this model provision addresses an agent's role in a Ulysses arrangement.
Rather, the agent may consent to such treatments for the principal if the principal's written grant of authority is sufficiently broad to encompass these decisions. However, an agent only has the authority to consent to electroconvulsive therapy for the principal if the principal expressly granted authority to consent to the principal's electroconvulsive therapy.

(3) An agent's decisions for the principal must be in good faith and consistent with the principal's instructions expressed in the principal's directive. If the directive fails to address an issue, the agent shall make decisions in accordance with the principal's instructions or preferences otherwise known to the agent. If the agent does not know the principal's instructions or preferences, the agent shall make decisions in the best interests of the principal.

(4) If the principal grants the agent authority to make decisions for the principal in circumstances in which the principal still has capacity, the principal's decisions when the principal has capacity override the agent's decisions.

(5) Except as otherwise prohibited by law, an agent has the same right as the principal to receive, review, and authorize the use and disclosure of the principal's health care information as is necessary for the agent to carry out the agent's duties for the principal.

(6) Health care decisions an agent makes for a principal are effective without judicial approval.

(7) When an incapacitated principal refuses inpatient mental health treatment and/or psychotropic medication, the principal's agent only has the authority to consent to such treatments for the principal if the principal's irrevocable directive expressly authorizes the agent to consent to the applicable treatment.

(8) A principal may not designate as her agent an owner, operator, or employee of a facility at which the principal is receiving care or a relative of such owner or operator unless the designated person is related to the principal by blood, marriage, or adoption.

Permissible Scope of Directives
In directives, principals may issue instructions or appoint agents to make decisions concerning all aspects of their mental-health treatment, except as limited by subsection 4 below, including:

(1) Consent to or refusal of specific types of mental health treatments, including psychotropic medication, electroconvulsive therapy, and inpatient mental health treatment; Consents to electroconvulsive therapy must be express;

(2) Preferences concerning treatment facilities and care providers;
(3) Nomination of a guardian for the court to consider if guardianship proceedings commence; but
(4) Principals may not consent to or authorize agents to consent to psychosurgery in a directive.

Revocation of Directives; Procedures for Implementing Self-Binding Arrangements

(1) A principal may freely revoke a directive even if she is incapacitated unless the principal makes her directive irrevocable during periods of incapacity. To be irrevocable, the directive shall:
(a) State that the directive remains irrevocable during periods of incapacity; and
(b) Contain an attestation from a mental health professional that the principal had capacity at the time of executing the directive.
(2) A principal with capacity or a principal without capacity who did not make her directive irrevocable during periods of incapacity may revoke a directive by:
(a) A written statement revoking the directive;
(b) A subsequent directive that revokes the original directive. If the subsequent directive does not revoke the original directive in its entirety, only inconsistent provisions in the original directive are revoked; or
(c) Physical destruction of the directive with the intent that it be revoked.
(3) When a principal with capacity consents to treatment that is different than the treatment requested in her directive or refuses treatment that the principal requested in her directive, this consent or refusal does not revoke the entire directive but is a waiver of the inconsistent provision.
(4) A principal has a right to form a self-binding arrangement for care. Such an arrangement allows the principal to obtain treatment in the event an acute episode renders the principal incapacitated. To provide advance consent to inpatient treatment despite the principal's illness induced refusals, in her directive, a principal shall:
(a) Make her directive irrevocable pursuant to subsection 3 above; and
(b) Consent to admission in an inpatient treatment facility.
(c) If the principal wants administration of psychotropic medication despite the principal's illness induced refusals of medication, the principal

578 See WASH. REV. CODE §§ 71.32.080, 71.32.140 which inspired this model provision, but this provision enables a patient to enter a Ulysses arrangement, sets forth procedures for administration of psychotropic medication under a Ulysses arrangement, and assists physicians in making capacity determinations with a rebuttable presumption of incapacity when the patient demands discharge in contravention of her irrevocable directive.
shall expressly consent to psychotropic medication in the irrevocable directive.

(5) If the principal forms a self-binding arrangement for treatment but then refuses admission despite the directive's instructions to admit, the facility shall respond as follows:
(a) The facility shall, as soon as practicable, obtain the informed consent of the principal's agent, if any is designated.
(b) Two mental health professionals shall within 24 hours of the principal's arrival at the facility evaluate the principal to determine whether the principal has capacity and document in the principal's medical record a summary of findings, evaluations, and recommendations.
(c) The principal's statements in her directive requesting inpatient treatment upon activation of the directive, combined with activation of the directive, and contemporaneous refusals of treatment requested in the directive creates a rebuttable presumption that the principal lacks capacity.
(d) If the evaluating mental health professionals determine the principal lacks capacity, the principal shall be admitted into the treatment facility pursuant to the principal's directive. The treating mental health professional shall document in the principal's medical records all treatment administered. After twenty-one days from the date of admission, if the principal has not regained capacity or has regained capacity but refuses to consent to remain for additional treatment, the facility shall release the principal during daylight hours unless the principal is detained pursuant to involuntary commitment standards.
(6) If a principal who has been determined to lack capacity continues to refuse inpatient treatment, the principal may immediately seek injunctive relief for release from the facility.
(7) If a principal with an irrevocable directive consenting to inpatient treatment refuses psychotropic medication through words or actions, only a licensed psychiatrist may administer psychotropic medication only if:
(a) The principal expressly consented to psychotropic medication in the principal's irrevocable directive;
(b) The agent, if one was designated, consented to psychotropic medication; and
(c) Two licensed psychiatrists recommend in writing treatment with the specific psychotropic medication.