AN AMERICANS WITH DISABILITIES ACT CRITIQUE OF ADVANCE DIRECTIVE OVERRIDE PROVISIONS

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Abstract

This Article argues that many mental health advance directive (mental health directive) statutes violate the Americans with Disabilities Act (ADA). Advance directives empower people to determine care to be administered when they lack capacity to provide informed consent. General advance directives (generic directives) typically address end-of-life care. Mental health directives govern treatment administered during periods of incapacity caused by acute episodes. Because end-of-life decision-making is different than planning for episodic mental illness, half of the states have enacted separate mental health directive statutes. These specialized statutes often provide doctors more leeway to force treatment on a patient in contravention of a directive than do generic directive statutes. People with mental illness who form directives are qualified individuals with a disability under the ADA. When a state makes it easier for a doctor to override mental health directives than the directives of other people, it excludes people with mental illness from full participation in the state’s advance directive program because of their disability. The ADA does not require public entities to allow individuals to participate in or benefit from programs where the individuals pose a direct threat to the health or safety of others (direct threat exception). However, mental health directive statutes often fail to require an individualized dangerousness assessment at the time of directive abrogation as is mandated by the ADA. This Article proposes a model override provision which allows doctors flexibility to respond to threats to the health or safety of others and complies with the ADA. The recommended approach also clarifies the relationship between mental health directive laws and involuntary commitment laws which is currently vague at best.

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INTRODUCTION

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There can be no doubt that all patients, including patients with severe mental illness, have the right to participate meaningfully in the course of their treatment, to be free from unnecessary or unwanted medication, and to have their rights of personal autonomy and bodily integrity respected by agents of the state.²

INTRODUCTION

Advance directives empower people to determine care to be administered when they lack capacity to provide informed consent.³ General

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³ See John Q. La Fond & Deborah Srebnik, The Impact of Mental Health Advance Directives on Patient Perception of Coercion in Civil Commitment and Treatment
advance directives (generic directives) typically address end-of-life care, but mental health advance directives (mental health directives) govern treatment administered during periods of incapacity caused by acute mental illness episodes. Because end-of-life decision-making implicates different issues than planning for episodic mental illness, half of the states have enacted separate mental health directive statutes. The majority of these specialized statutes make it easier for a doctor to override a mental health directive than do their counterpart generic directive statutes.

One example of a typical generic directive statute, the Uniform Health Care Decisions Act (Uniform Act) allows doctors to override a generic directive for reasons of conscience, or if the requested treatment is medically ineffective or contrary to generally accepted health care standards. When the institution does not comply with the directive, it must inform the patient, make reasonable efforts to assist in transferring the patient to another institution willing to comply with the directive, and provide continuing care until transfer.

Mental health directive statutes often provide doctors more leeway to force treatment on a patient. Many of these statutes authorize directive abrogation in emergencies (typically not further defined), pursuant to court order (without setting forth criteria for issuance of such orders), and in the commitment context (sometimes without further limitation). Generally,
they do not require the institution to transfer the patient to a facility willing to honor the mental health directive. The typical generic directive statute allows doctors to decline to administer inappropriate treatments, but the typical mental health directive statute authorizes doctors to force treatment on a patient in certain circumstances.9

This Article argues many mental health directive override provisions violate the Americans with Disabilities Act (ADA).10 It proposes a model override provision which allows doctors flexibility to respond to threats to the health or safety of others and complies with the ADA.11 Part I(A) gives the reader an advance directives primer. It defines an override provision as a statutory provision allowing doctors to abrogate the patient’s directive in certain situations.12 Part I(A) also explores the common ground as well as the key differences between generic and mental health directives.

Part I(B) lays out the framework for an ADA challenge to a statutory scheme which give doctors greater leeway to override a mental health directive than a generic one. Title II of the ADA states no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity.13 People with mental illness who form mental health directives are qualified individuals with a disability under the ADA.14 When a state makes it easier for a doctor to override mental health directives than the directives of other people, the state discriminates against people with mental illness due to their disability.15

The ADA does not require public entities to allow an individual to participate in or benefit from services or programs where the individual poses a direct threat to the health or safety of others (direct threat exception).16 Therefore, a statutory scheme which gives more expansive

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9 VHA Report, supra note 5, at 6.
10 See infra Part II(B).
11 See infra Part III(A).
12 VHA Report, supra note 5, at 6; see e.g. UHCDA §7(e)-(f); Jeffrey W. Swanson et al., Overriding Psychiatric Advance Directives: Factors Associated with Psychiatrists’ Decisions to Preempt Patients’ Advance Refusal of Hospitalization and Medication, 31 LAW & HUM. BEHAV. 77 (2007).
14 29 C.F.R. §1630.2(h) (2001) (disability includes “[a]ny mental or psychological disorder, such as... emotional or mental illness”; Hargrave v. State of Vermont, 340 F.3d 27, 36 (2d Cir. 2003).
15 Hargrave, 340 F.3d at 37.
16 42 U.S.C §12182(b)(3); Velez, 974 F.Supp.2d at 731.
override authority only in the mental health context is not exempt from the antidiscrimination mandate of the ADA unless an exception like the direct threat exception applies.\textsuperscript{17}

Part II(B) illustrates that many mental health directive statutes authorizing directive abrogation in emergencies, by court order, or in the commitment context do not fall within the direct threat exception to the nondiscrimination mandate of the ADA. The ADA implementing regulations require the public entity to make an individualized assessment of whether the individual poses a direct threat to the health or safety of others based on current medical knowledge or the best available objective evidence.\textsuperscript{18} Part II(B)(3) shows many mental health directive statutes allowing doctors to override a directive in the commitment context, without further limitation, fail to require an individualized dangerousness assessment at the time of directive abrogation as is required by the ADA.\textsuperscript{19} Even if the committing court determined the person was dangerous at the time of initial commitment, after a period of hospitalization and treatment, the person may no longer pose a direct threat to the health or safety of others.\textsuperscript{20}

Similarly, Part II(B)(1) argues authorizing a doctor to override a mental health directive in emergencies (often not further defined) potentially violates the ADA.\textsuperscript{21} Without clarification, “emergencies” arguably include episodes endangering the patient’s mental health. If “emergencies” were defined this broadly, many acute episodes are “emergencies” because, if left untreated, most episodes could lead to deterioration of the patient’s cognitive functions.\textsuperscript{22} If most acute episodes were emergencies, doctors could force treatment in situations where patients are not a direct threat to the health or safety of others and are not subject to forced medication under commitment laws which typically require dangerousness.\textsuperscript{23} Such situations do not fall under the direct threat exception.\textsuperscript{24} Allowing directive abrogation

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\textsuperscript{17} 42 U.S.C §12182(b)(3); see also, Hargrave, 340 F.3d at 37.
\textsuperscript{18} 28 C.F.R. 35.139(nondiscrimination on the basis of disability in state and local governmental services); Velez 974 F.Supp.2d at 732.
\textsuperscript{19} 28 C.F.R. 35.139; Hargrave, 340 F.3d at 36.
\textsuperscript{20} Hargrave, 340 F.3d at 36.
\textsuperscript{21} See infra Part II(B)(1); VHA Report, supra note 5, at 6.
\textsuperscript{23} 42 U.S.C. §12182(b)(3).
\textsuperscript{24} Id.
in such situations violates the ADA and applicable commitment laws.\footnote{\cite{Hargrave}, 340 F.3d at 36.}

Finally, Part II(B)(2) posits authorizing doctors to override mental health directives \textit{pursuant to court order}, without further guidance, is overly broad and does not comply with the ADA direct threat exception.\footnote{See infra Part II(B)(2).} Allowing directive abrogation pursuant to court order without providing guidance as to the criteria for issuing such orders or as to the timeliness of the order in relation to the directive contravention does not ensure an individualized dangerousness assessment at the time of directive abrogation, as is required by the ADA.\footnote{See infra Part II(B)(2).}

Part III articulates a model override provision for states to adopt.\footnote{See infra Part III.} Part III(A) analyzes two other recommended override provisions, one from the National Ethics Committee of the Veterans Health Administration (Committee), and one from a preeminent legal scholar.\footnote{VHA Report, \textit{supra} note 5, at 7; Bruce J. Winick, \textit{Advance Directive Instruments for Those with Mental Illness}, 51 U. MIAMI L. REV. 57, 71-75 (1996).} The Committee’s approach, adopting the typical generic directive override provision in the mental health context, fails to allow flexibility to doctors to respond to emergencies endangering the health or safety of others.\footnote{Winick, \textit{supra} note 29, at 71-75.} The scholar’s approach allows directive abrogation in the police power commitment context but not in the \textit{parens patriae} commitment context.\footnote{Winick, \textit{supra} note 29, at 71-75.} This focuses on the wrong issue, the basis of commitment, and fails to require an individualized dangerousness assessment at the time of directive abrogation.\footnote{See infra Part III.}

Part III(B) provides this Article’s model approach which does not single out people with mental illness for different treatment.\footnote{See infra Part III(B).} Rather, for all forms of directives, it adopts the Uniform Act’s override provision and adds another override authority – allowing doctors to contravene a directive when following the directive would pose a direct threat to the health or safety of others.\footnote{UHCDA §7(e)-(f).} Such direct threat situations could include mental health emergencies but also other situations such as instances in which a contagious tuberculosis patient refuses treatment and quarantine in her directive.\footnote{See infra Part III(B).} The recommended approach tracks the language of the direct threat exception.\footnote{42 U.S.C. §12182(b)(3).} It also clarifies the relationship between mental health

\begin{thebibliography}{99}
\item \cite{Hargrave}, 340 F.3d at 36.
\item See infra Part II(B)(2).
\item See infra Part II(B)(2).
\item See infra Part III.
\item Winick, \textit{supra} note 29, at 71-75.
\item Winick, \textit{supra} note 29, at 71-75.
\item See infra Part III(B).
\item UHCDA §7(e)-(f).
\item See infra Part III(B).
\item 42 U.S.C. §12182(b)(3).
\end{thebibliography}
I. BACKGROUND ON ADVANCE DIRECTIVES AND THE ADA

This Part provides background on advance directives and the ADA. Part I(A) sets forth an advance directives primer. It defines an override provision and explores the common ground and key differences between generic and mental health directives. Part I(B) lays out the framework for an ADA challenge to a mental health directive statute which provides clinicians greater authority to abrogate a mental health directive than a generic one.

A. Advance Directives Primer

This background Section enables the reader to have a basic understanding of advance directives.

1. Override Provision Defined

Modern informed consent law requires doctors to provide patients relevant information about the risks and benefits of any proposed treatment and to obtain the patient's informed consent before administering treatment. To give valid informed consent, the patient must be capable of making a knowing and voluntary decision concerning treatment. For a treatment decision to be knowing and voluntary, the patient must have capacity. Advance directive statutes typically define capacity as the

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38 VHA Report, supra note 5, at 6-7.
39 Winick, supra note 29, at 71-75.
40 See infra Part I(B).
42 See infra note 43.
43 See e.g., FLA. STAT. §§765.101 (8-9) (2013) (defining incapacity to mean the patient is unable to communicate a willful and knowing health-care decision and defining informed consent as consent voluntarily given by a patient after a sufficient explanation and disclosure of risks and alternatives to make a knowing health-care decision)
capacity to make and communicate healthcare decisions and understand the significant benefits, risks, and alternatives to proposed treatment.\footnote{See e.g., UHCDA §1(3).}


When injury or illness disrupts the patient's capacity, an advance directive enables the patient to provide informed consent in advance so doctors can administer care.\footnote{See John Q. La Fond & Deborah Srebnik, The Impact of Mental HealthAdvance Directives on Patient Perceptions of Coercion in Civil Commitment and Treatment Decisions, 25 INT’L J. L. & PSYCHIATRY 537-40 (2002); Fl. STAT. §765.102(2) (2013).} Statutes regulating advance directives require doctors to follow the patient’s preferences articulated in a directive except in narrowly defined circumstances. These “override provisions” allow doctors to abrogate the patient’s directive in certain situations, thereby shielding clinicians from liability when they contravene directives so long as they do so within the parameters of the override provision.\footnote{VHA Report, supra note 5, at 6. Justine A. Dunlap, Mental Health Advance Directives: Having One’s Say?, 89 KY. L. J. 327, 364-371 (2001).}

2. Generic and Mental Health Directives: the Common Ground

The primary purpose of both generic and mental health directives is to support patient self-determination by empowering patients to exercise control over treatment administered when illness has destroyed capacity. Both generic and mental health directives come in various forms.\footnote{Dunlap, supra note 50, at 347-54.}
Instructional directives enable a patient to specify treatment to be administered when the patient is incapacitated.\textsuperscript{52} In the end-of-life context, an instructional directive might state, "if I am in a permanent vegetative state, I do not want doctors to administer artificial hydration and nutrition."\textsuperscript{53} In the mental health context, an instructional directive might state, "if an episode destroys my capacity, I consent to antipsychotic medication."\textsuperscript{54}

Proxy directives, otherwise known as durable powers of attorney, allow patients, also known as principals, to appoint trusted representatives or agents to make health care decisions for them.\textsuperscript{55} In both the end-of-life and mental health contexts, clinicians often recommend hybrid directives which enable patients to give instructions and designate agents.\textsuperscript{56} Arguably, the hybrid directive best supports patient self-determination because it enables the patient to give guidance to her doctors and her agent.\textsuperscript{57} No directive can address every situation that may arise during the chaos caused by a terminal illness or an acute mental illness episode.\textsuperscript{58} Even in an unforeseen situation, the hybrid directive allows the patient to exercise control over her care through her agent.\textsuperscript{59}

3. Differences Between Generic and Mental Health Directives

Whereas a patient seeks to secure a dignified death through a generic directive, a patient strives to obtain a stable life or avoid unwanted side effects through a mental health directive.\textsuperscript{60} Because end-of-life decision-making is different than planning for episodic mental illness, half of the states have enacted separate mental health directive statutes.\textsuperscript{61} This Section explains how the end-of-life and episodic mental illness contexts are distinguished and identifies key differences between generic and mental health directive statutes.\textsuperscript{62} This comparison enables the reader to appreciate why states often craft more expansive override provisions for mental health
directives than for generic ones.63

a. The Commitment Context and the Illness Induced Treatment Refusal

The relationship between mental health directive laws and commitment laws is vague at best.64 For example, in many states the agent named in the mental health directive is unauthorized to place the principal in a locked mental health facility, coerce the principal to take psychotropic medication against her will,65 or subject the principal to electroconvulsive therapy.66 Forced hospitalization and treatment to prevent dangerousness are implicated in the mental health arena, not in the end-of-life context.67 This is because mental illness can prevent a patient from recognizing she is sick and cause her to refuse treatment to which she would otherwise consent if she were not in the midst of an episode.68 This phenomenon is an illness induced treatment refusal.69 Once an episode induces a person to refuse intervention, the primary means of obtaining treatment is through involuntary commitment.70

A basic summary of involuntary commitment law is necessary to appreciate why the interaction between mental health directive laws and commitment laws is vague.71 The state’s authority to commit people with mental illness derives from two components of sovereignty.72 The first is the police power, which is the authority to maintain peace and order.73 States define this as the authority to confine a person who is likely to be

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63 See VHA Report, supra note 5, at 6.
64 See supra note 37 and accompanying text.
65 See Advising Elderly Client, supra note 37, at §33:18.
68 See KAY REDFIELD JAMISON, AN UNQUIET MIND: A MEMOIR OF MOODS AND MADNESS 36 (1995); Davoli, supra note 22, at 1009 (asserting inability to accept that one is mentally ill is a symptom of mental illness); VHA Report, supra note 5, at 8 (stating patients entering a mania may not recognize that they are manic and refuse treatment)
70 Id. at 415.
71 See Advising the Elderly Client, supra note 37, at §33:18.
72 Addington v. Texas, 441 U.S. 418, 427 (1979); Clausen, supra note 45, at 9-12 (providing explanation of commitment law).
73 Id.
dangerous to others.\textsuperscript{74} The second is the \textit{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.\textsuperscript{75}

According to the U.S. Supreme Court, civil commitment imposes a massive curtailment of liberty warranting strict commitment criteria.\textsuperscript{76} The Supreme Court decided the clear and convincing evidence standard meets due process guarantees for civil commitment proceedings, but the preponderance of the evidence standard is not adequate.\textsuperscript{77} For police power commitment, states typically require the government to show because of mental illness, the person is a danger to others.\textsuperscript{78} First, the state must prove the person suffers from a mental illness or disorder which is often defined as a substantial disorder of the emotional processes, thought, or cognition that grossly impairs judgment, behavior or capacity to recognize reality.\textsuperscript{79} Second, most states require proof that mental illness caused the dangerousness.\textsuperscript{80} Third, the government must prove dangerousness itself, often defined as a substantial likelihood in the near future the person will inflict serious bodily harm on another as evidenced by recent behavior.\textsuperscript{81} Many jurisdictions demand a finding of an overt act as a prerequisite to involuntary commitment.\textsuperscript{82}

For \textit{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.\textsuperscript{83} Typically, two categories of people are subject to \textit{parens patriae} commitment: those at risk of suicide and those whose illnesses render them unable to provide for their basic needs.\textsuperscript{84} States which have an overt act requirement for police power

\begin{itemize}
\item \textsuperscript{74} \textit{Id.}
\item \textsuperscript{75} \textit{Id.}
\item \textsuperscript{77} \textit{Addington}, 441 U.S. at 432-33.
\item \textsuperscript{78} \textsc{Christopher Slobogin et al., Law and the Mental Health System: Civil and Criminal Aspects} 23, 705 (5th ed. 2008).
\item \textsuperscript{79} Foucah v. Louisiana, 504 U.S. 71, 112 (1992); Slobogin et al., \textit{supra} note 47, at 723; Coyle, \textit{supra} note 45, at §4; N.M. Stat. Ann. §43-1-3(O) (2013).
\item \textsuperscript{80} Slobogin et al., \textit{supra} note 78, at 726.
\item \textsuperscript{81} Coyle, \textit{supra} note 45, at §4; \textit{In re B.T.}, 891 A.2d 1193 (N.H. 2006); Fla. Stat. §394.460(1)(b) (2013).
\item \textsuperscript{82} Kan. Stat. Ann. §59-2946.
\item \textsuperscript{83} Slobogin et al., \textit{supra} note 78, at 705.
\item \textsuperscript{84} \textsc{Donald H.J. Hermann, Mental Health and Disability Law in a Nutshell} 159 (1997); Doe v. Gallinot, 486 F. Supp. 983 (C.D. Cal. 1979), aff’d, 657 F.2d 1017 (9th Cir. 1981) (asserting the gravely disabled standard meets constitutional muster by a warning against overbroad construction); \textsc{Michael L Perlin, Mental Disability Law} 119, 125 (2d ed. 2005).}

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commitment also have the requirement for *parens patriae* commitment. For both types of commitment, almost all states require consideration of less restrictive alternatives to involuntary hospitalization which allow for care and prevent danger, such as outpatient treatment, day or night treatment in a hospital, placement in the custody of a loved one, or home health services.

Generally, involuntary commitment procedures are as follows. States authorize involuntary emergency admission and evaluation without a full adjudicatory hearing. Typically, states authorize police to detain and transport to a hospital a person the officer concludes meets emergency detention and screening criteria which is essentially the same as for commitment. At the facility, a doctor examines the person to determine if emergency treatment is necessary to protect the safety of the person or others. States impose strict time limits under which a person may be subject to involuntary admission and examination. For example, in Florida, within 72 hours from the time the person arrives at the facility, a clinician must examine the person to determine if she meets involuntary commitment criteria. If she does not, the facility must release the patient unless she provides informed consent to remain as a voluntary patient.

States have formal adjudicatory procedures for involuntary commitment. They require a formal hearing, notice, and counsel and mandate periodic reviews of the legal status of the committed patient to evaluate whether she continues to meet commitment criteria. Usually, a judge makes the decision to commit, but many states enable the patient to request a jury trial. Typically, states require a review hearing after initial commitment, usually from between three months to a year after admission.

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85 HERMANN, *supra* note 84, at 161.
86 SLOBOGIN ET AL., *supra* note 78, at 782; FLA. STAT. §394.460(1) (b) (2013); HAW. REV. STAT. §334-60.2 (2013) (both Hawaii and Florida not requiring a finding that all available less restrictive treatment alternatives were adjudged inappropriate); Randolph v. Cervantes, 950 F. Supp. 771, 777 (S.D. Miss. 1996).
87 HERMANN, *supra* note 84, at 165.
88 Coyle, *supra* note 45, §2; see e.g., FLA. STAT., §394.463(2) (2013).
89 See e.g., FLA. STAT. §394.463.
90 SLOBOGIN ET AL., *supra* note 45, at 811, *see e.g.*, VA. CODE ANN. §37.2-809 (stating the duration of temporary detention shall not exceed 48 hours before there is a hearing).
91 FLA. STAT. §394.463(2) (2013).
92 Id.
93 SLOBOGIN ET AL., *supra* note 45, at 705.
94 See *e.g.*, FLA. STAT. §§394.467(6) (2013); 394.4599 (2013); MASS. GEN. LAWS ch. 123, §5 (2013); SLOBOGIN ET AL., *supra* note, at 705.
95 SLOBOGIN ET AL., *supra* note 45, at 705.
There is no consensus concerning the appropriate interaction of commitment laws and mental health directive laws.\textsuperscript{97} One of the reasons the Uniform Law Commission refrained from enacting a model mental health directive statute is this lack of consensus.\textsuperscript{98} The issue of whether a directive refusing treatment limits a doctor’s authority to treat a committed patient is not implicated with generic directives.\textsuperscript{99} In the end-of-life context, following a directive refusing intervention does not endanger the safety of others and does not contravene court orders authorizing forced hospitalization and treatment.\textsuperscript{100} Moreover, the illness induced treatment refusal phenomena is one reason most states with separate mental health directive statutes only allow a patient with capacity to revoke a mental health directive even though a majority of all states allow the principal to revoke a generic directive at any time, even if the patient has lost capacity.\textsuperscript{101}

b. Mental Health Directives Repeatedly Used

A doctor follows a generic directive during one key time frame in a person's life, the time before death, after terminal illness or injury has destroyed the patient's capacity.\textsuperscript{102} However, mental illness is often episodic. Doctors may need to follow the directive repeatedly over the patient's life when the patient suffers from acute episodes brought on by the stresses of life.\textsuperscript{103} The directive provides guidance for treatment to be administered in response to each episode.\textsuperscript{104} It becomes a crisis intervention plan, potentially preventing: involuntary treatment, administration of treatment with harmful side effects, or safety risks caused by the use of restraint or seclusion.\textsuperscript{105}

The mental health directive’s potential to be a blueprint for crisis

\textsuperscript{97} Advising the Elderly Client, supra note 37, at §33:18.
\textsuperscript{98} See Clausen, supra note 45, at Part II (identifying the ways in which the Uniform Act fails people with mental illness).
\textsuperscript{99} See generally, Backlar, supra note 4, at 262; Dunlap, supra note 50, at 347; Elizabeth M. Gallagher, Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals, 4 PSYCHOL. PUB. POL’Y & L. 746, 780 (1998).
\textsuperscript{100} See supra notes 64-99 and accompanying text.
\textsuperscript{101} VHA Report, supra note 5, at 9 (stating that in 36 out of 50 states, incapacitated patients may revoke generic directives. However, in 18 out of 25 states with mental health directive statutes, only patients with capacity may revoke mental health directives).
\textsuperscript{102} Backlar, supra note 4, at 261-62.
\textsuperscript{103} Robert D. Miller, Advance Directives for Psychiatric Treatment: A View from the Trenches, 4 PSYCHOL. PUB. POL’Y & L. 728, 734 (1998).
\textsuperscript{104} Winick, supra note 29, at 81-82.
intervention may be one reason most states with specialized mental health directive statutes provide for automatic expiration of mental health directives after 2 to 5 years. Proponents of automatic expiration argue it ensures mental health directives continue to reflect the patient’s instructions over time as illnesses and treatment options evolve. Moreover, automatic expiration incentivizes patients and clinicians to maintain ongoing dialogue to ensure instructions are kept up-to-date. No state legislature imposes automatic expiration on generic directives.

c. Mental Health Treatment Can Be Particularly Intrusive

Mental health treatments can be particularly intrusive and potentially dangerous. Although antipsychotic medication minimizes psychosis, it potentially causes serious side effects, such as tardive dyskinesia, a disabling neuromotor syndrome. Because of the potentially harmful side effects, courts and legislatures consider psychiatric medication to be an intrusive treatment. Electroconvulsive therapy (ECT), a widely used treatment, is considered even more invasive than drug therapy. Its side effects include memory loss, dental trauma, bone fractures, skin burns, and possible brain damage. Because of the intrusive nature of ECT, many states do not empower a principal to convey authority, even expressly, to an agent to consent to the patient’s ECT; a court order is required.

Psychosurgery, defined as any surgery performed to modify or control thoughts, feelings, or behavior, rather than treat a known, diagnosed physical disease of the brain is discredited and dangerous. Most states prohibit patients from consenting to or conveying authority to an agent to...

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106 VHA Report, supra note 5, at 10; see e.g., OHIO REV. CODE ANN. §2135.03 (West 2013); OR. REV. STAT. ANN. §127.702 (2013); TENN. CODE ANN. §33-6-1003 (2013); TEX. CIV. PRAC. & REM. CODE ANN. §137.002(b) (West 2013)
107 VHA Report, supra note 5, at 10.
108 Id.
109 Id.
110 SLOBOGIN ET AL., supra note 78, at 31.
111 Id. at 37.
113 Jorgensen, supra note 66, at 1; CAL. PROB. CODE §4052 (West 2013); DC STAT. §7-1231.07(e) (2013); N.H. REV. STAT. §464-A: 25 (2013); OR. REV. STAT. §127.540 (2013); TEX. HEALTH & SAFETY CODE ANN. §166.152(f) (2013).
115 See Jorgensen, supra note 66, at 1.
116 See CAL. CODE WELF. & INST. §5325 (West 2013).
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consent to psychosurgery in a directive. Finally, courts have recognized institutionalization can traumatize patients and subject patients to risks of abuse from fellow patients and from staff. For this reason, there are strict commitment criteria and some jurisdictions limit an agent’s authority to hospitalize a principal for inpatient mental health treatment.

B. The Framework for the ADA Challenge

This Section sets out the framework for an ADA challenge to a statutory scheme which provides greater leeway to a doctor to override a mental health directive than a generic directive. The ADA was enacted in 1990 as the most comprehensive effort to remedy discrimination against people with disabilities. Congress determined discrimination against people with disabilities persists especially in such areas as institutionalization, segregation, and relegation to lesser services, programs, and other opportunities. Title II of the ADA states no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. To prove a Title II violation, the plaintiff must establish she: (1) is a qualified individual with a disability; (2) was excluded from participation in a public entity's services, programs, or activities or was otherwise discriminated against by a public entity; and (3) such exclusion or discrimination was due to her disability. Section 504 of the Rehabilitation Act imposes the same requirements. Therefore, courts evaluating a challenge to a mental health

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117 See e.g., CAL. PROB. CODE §4652 (West 2013); OR. REV. STAT. §127.540 (2013); TEX. HEALTH & SAFETY CODE ANN. §166.152 (West 2013); WASH. REV. STAT. §11.92.043 (2013).

118 O'Connor v. Donaldson, 422 U.S. 563, 574-75 (1975); Paddock v. Chacko, 552 So.2d 410, 413-14 (Fla. Dist. Ct. App. 1988) (“mental illness may be caused or intensified by institutionalizing mental patients”).

119 Clausen, supra note 45, at 47-48; see e.g., TEX. HEALTH & SAFETY CODE ANN. §166.152(f)(1) (West 2013); WIS. STAT. ANN. §155.20(2) (West Supp. 2013); Cohen v. Bolduc, 760 N.E.2d 714, 718 n. 15 (Mass. 2002) (describing instances where states authorize patients to create directives but do not allow patients to empower agents to consent to inpatient mental health treatment).


121 42 U.S.C §12101(a)(2, 3, 5).


123 Rodriguez v. City of New York, 197 F.3d 611, 618 (2d Cir. 1999).

directive statute consider Rehabilitation Act and ADA claims in tandem.\footnote{125}

1. Qualified Individual with a Disability?

Under the ADA, a "qualified individual" is a person "with a disability who, with or without reasonable modifications to rules, policies or practices meets the essential eligibility requirements for participation in programs or activities provided by a public entity."\footnote{126} Generally, any individual challenging a mental health directive statute would be a "qualified individual" under the ADA because there would be little reason for a person who has no mental illness to form a mental health directive. Mental illness qualifies as a disability under the ADA which defines a disability to include any mental or psychological disorder such as an emotional or mental illness.\footnote{127} When Congress amended the ADA in 2009, it clarified that the threshold question of whether a person has a disability under the ADA "should not demand extensive analysis."\footnote{128} Rather, the focus should be on whether the covered entity discriminated against the individual based on her disability.\footnote{129} The recent amendments to the ADA clarify even episodic illnesses, such as Bipolar Disorder, qualify as disabilities under the ADA.\footnote{130} Therefore, any individual with a mental illness who forms a mental health directive, even if her mental illness is episodic, is an individual with a disability under the ADA.\footnote{131}

2. Exclusion from Service, Program, or Activity?

A person launching an ADA challenge to a mental health directive override provision alleges when doctors have wider latitude to override a mental health patient's directive than the directives of other patients, the mental health patients are excluded from full participation in the state's program to protect patient self-determination.\footnote{132} When the state makes it easier for a clinician to override a patient's wishes in an advance directive

\begin{footnotes}
\footnote{125}{Velez, 974 F.Supp.2d at 730; 42 U.S.C. §12134(b); Olmstead v. L.C., 527 U.S. 581, 606, n. 16 (1999).}
\footnote{126}{42 U.S.C. §12131(2).}
\footnote{127}{29 C.F.R. 1630.2(h) (2001); E.E.O.C. v. J.D. Hunt Transport, Inc., 321 F.3d 69, 74 (2d Cir. 2003).}
\footnote{128}{Pleading disability.}
\footnote{129}{Lawrence D. Smith & Molly Hughes Cherry, The ADA Amendments Act of 2008: Practical Implications for Employers in 2012 and Beyond, 79 DEF. COUNS. J. 32, 33 (2012).}
\footnote{130}{Id.}
\footnote{131}{Id.}
\footnote{132}{See e.g., Hargrave, 340 F.3d at 32.}
\end{footnotes}
only in the mental health context, the state limits the person's fundamental right to bodily integrity.\textsuperscript{133}

In \textit{Hargrave v. Vermont}, the Second Circuit Court of Appeals ruled on an ADA challenge to a Vermont statute setting forth a process which singled out mentally ill prisoners and patients civilly committed for mental illness who had been adjudicated dangerous to themselves or others when they were committed.\textsuperscript{134} The Vermont statute authorized doctors to override the advance directives \textit{only} of mentally ill civilly committed or imprisoned patients in order to forcibly medicate these people.\textsuperscript{135} For these mentally ill individuals, Vermont did not require appointment of a guardian or revocation of the directive to support doctors' forced medication in contravention of the directive.\textsuperscript{136} However, for other incapacitated patients, Vermont only allowed doctors to override the directive if the patient revoked the directive or the court appointed a guardian to protect the person's best interests.\textsuperscript{137} \textit{Hargrave} determined Vermont excluded these people with mental illness from the relevant state service, program, or activity – the program empowering people to protect their autonomy through advance directives.\textsuperscript{138}

In \textit{Disability Rights New Jersey, Incorporated v. Velez}, an organization representing psychiatric patients treated at New Jersey state psychiatric hospitals alleged patients were forced to consume psychiatric medication against their will, in nonemergency situations, in violation of the ADA.\textsuperscript{139} The New Jersey defendants argued the text of the ADA and the case law interpreting it did not support the plaintiff's position that the right to refuse treatment is a "service, program, or activity" under the ADA.\textsuperscript{140} \textit{Velez} rejected this defense.\textsuperscript{141} The Federal Code defines "service, program, or activity" as all of the operations of a department, agency, special purpose district, or other instrumentality of the state or the local government.\textsuperscript{142} Moreover, implementing regulations clarify ADA coverage extends to all services public entities make available.\textsuperscript{143} Courts have interpreted this broad

\textsuperscript{133} Winick, \textit{supra} note 29, at 71-75
\textsuperscript{134} \textit{Hargrave}, 340 F.3d at 31-34.
\textsuperscript{135} \textit{Id.} at 31-32.
\textsuperscript{136} \textit{Id.} at 37.
\textsuperscript{137} \textit{Id.}
\textsuperscript{138} \textit{Id.} at 38.
\textsuperscript{140} \textit{Id.} at 736.
\textsuperscript{141} \textit{Id.}
\textsuperscript{142} 29 U.S.C. §794(b)(1) (Rehabilitation Act definition of "program or activity" pursuant to nondiscrimination under federal grants and programs); \textit{Velez}, 974 F.Supp.2d at 736.
\textsuperscript{143} 28 C.F.R. 35.102(a).
language to apply to anything a public entity does.144 "Program, service, or activity" is a catchall phrase prohibiting all discrimination by a public entity, regardless of context.145 For example, state health insurance is a "program, service, or activity." Velez held New Jersey's differential treatment in its handling of a patient's right to refuse treatment was a "program, service, or activity" which could not avoid ADA nondiscrimination obligations.146

3. Was Exclusion or Discrimination Due to Disability?

Individuals alleging the override provision violates the ADA must prove the discrimination was due to the individual's mental illness.147 The state's program enabling people to form advance directives discriminates on the basis of mental illness if the program treats a person with mental illness in a particular set of circumstances differently than it treats people who do not have mental illness in the same circumstances.148

To prove an ADA violation, it is not necessary to prove the state program discriminated against all people who have the particular disability, mental illness.149 For example, in Olmstead v. Zimring, the court found the state excluded people from a state program by reason of their mental illness, in violation of the ADA, where the state did not exclude all mentally ill people from the program but only people who had been institutionalized for mental illness.150 Therefore, discrimination based on the severity of the disability is still unlawful discrimination under the ADA.151

Similarly, Hargrave concluded it was immaterial the Vermont act applied only to a subset of people with mental illness instead of all people with mental illness.152 The Vermont law authorized clinicians to override the directives only of people who were mentally ill, dangerous, committed, and incompetent to make treatment decisions.153 Discrimination on the basis of the severity of the disability still violates the ADA.154

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145 Velez, 974 F.Supp.2d at 736.
146 Id.
147 Id. at 730; 29 U.S.C §794(a).
148 Hargrave, 340 F.3d at 37.
149 Id.
151 Hargrave, 340 F.3d at 36-37.
152 Id.
153 Id.
154 Id.
that of all the patient population incompetent to refuse treatment, only patients committed for mental illness were subject to the directive abrogation procedures. Vermont established a procedure through which only people with mental illness found to be incompetent would have their directives overridden in family court. Equally incompetent people who suffered from physical illness or injury would only have their directives overridden in probate court after appointment of a guardian to protect their interests.

4. Direct Threat Exception

The ADA does not require public entities to allow an individual to participate in or benefit from services or programs where the individual poses a “direct threat” to the health or safety of others. This is known as the direct threat exception. The ADA defines “direct threat” as a significant risk to the health or safety of others that cannot be eliminated by modification of policies or procedures or by providing auxiliary aids or services. The implementing regulations require the public entity to make an individualized assessment of whether the individual poses a direct threat. Assessments must rely on current medical knowledge or the best available objective evidence. The public entity must make a reasoned judgment about the nature, duration, and severity of the risk, the probability that actual injury will occur, and whether reasonable modification of policies or procedures will alleviate the risk.

In Hargrave, Vermont argued the court’s initial dangerousness determination at the time of commitment excluded committed patients from the ADA for the entirety of their commitment under the direct threat exception. Hargrave concluded the direct threat exception was not applicable. Vermont failed to demonstrate every person subject to the advance directive abrogation procedures posed a direct threat to others.

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155 Id.
156 Id.
157 Id.
158 42 U.S.C. §12182(b)(3).
159 Hargrave, 340 F.3d at 36.
161 28 C.F.R. 35.139 (nondiscrimination on basis of disability in state and local governmental services).
162 Id.
163 Id.
164 Hargrave, 340 F.3d at 35.
165 Id.
sufficient to exclude the person from the ADA.\textsuperscript{166} Vermont neglected to make an individualized assessment of the danger the individual posed at the time the individual’s advance directive was overridden.\textsuperscript{167} Under the Vermont procedures, 45 days could have passed between the initial commitment order and contravention of the advance directive.\textsuperscript{168} After 45 days of commitment and treatment, many patients will no longer pose a danger to themselves or others.\textsuperscript{169} Moreover, commitment in Vermont was based on a court’s determination the individual posed a danger to self or others.\textsuperscript{170} However, the ADA’s direct threat exception requires the person to pose a danger to others.\textsuperscript{171}

Similarly, in \textit{Velez}, state defendants argued patients subject to New Jersey’s procedures for forced psychiatric medication of certain patients was exempt from ADA protections under the direct threat exception.\textsuperscript{172} The forced medication policy operated as follows. Patients subject to the policy had all been civilly committed due to mental illness based on a court finding that at the time of commitment they were dangerous to themselves or others.\textsuperscript{173} One category of the patients subject to the procedure was patients with conditional extension of commitment pending placement.\textsuperscript{174} These people were initially involuntarily committed but were later determined to no longer be dangerous and were entitled to discharge.\textsuperscript{175} However, they were not yet discharged because they were awaiting placement.\textsuperscript{176} The policy authorizing forced medication did not apply to voluntarily committed patients.\textsuperscript{177} For these patients, there had never been a judicial finding in a commitment hearing that they were dangerous.\textsuperscript{178} Therefore, they had the right to refuse psychotropic medication outside of an emergency.\textsuperscript{179} The policy provided for administrative, rather than judicial hearings for the psychiatric patients (involuntarily committed and patients awaiting placement) to determine their continued dangerousness as a prerequisite to medicate them without their consent.\textsuperscript{180}

\textsuperscript{166} Id.
\textsuperscript{167} Id.
\textsuperscript{168} Id.
\textsuperscript{169} Id.
\textsuperscript{170} Id.
\textsuperscript{171} Id.
\textsuperscript{172} \textit{Velez}, 974 F.Supp.2d at 737.
\textsuperscript{173} Id. at 713-717.
\textsuperscript{174} Id.
\textsuperscript{175} Id.
\textsuperscript{176} Id.
\textsuperscript{177} Id.
\textsuperscript{178} Id.
\textsuperscript{179} Id.
\textsuperscript{180} Id.
Velez decided it was unjustified to apply New Jersey’s policy to one category of the mental health patients, those patients with conditional extension of commitment pending placement.¹⁸¹ A court had determined these patients no longer presented a danger and were eligible for discharge.¹⁸² These patients were merely awaiting placement.¹⁸³ Defendants argued the court’s finding of a lack of dangerousness for these patients did not preclude the patients from presenting a danger in the future while in state custody.¹⁸⁴ This argument was based on the fact mental illness is often episodic, making dangerousness fluctuate.¹⁸⁵ Velez decided New Jersey’s procedures for forced medication of patients awaiting placement could not escape ADA protections.¹⁸⁶ The direct threat exception did not apply.¹⁸⁷ A court had determined these patients no longer presented a danger.¹⁸⁸ Therefore, applying the New Jersey policy to patients awaiting placement was facially discriminatory based on their mental illness.¹⁸⁹ If any of the patients awaiting placement began to exhibit new signs of dangerousness, the state could follow standard procedures for instituting civil commitment based on dangerousness.¹⁹⁰

The Velez plaintiffs also argued the direct threat exception did not apply to the patients committed based on parens patriae authority.¹⁹¹ A court had committed these patients because they posed a threat to themselves.¹⁹² No court had ever found these patients posed a threat to others as required by the direct threat exception.¹⁹³ Velez acknowledged an inherent difference between patients committed under parens patriae as opposed to police power authority.¹⁹⁴ Generally, the principle of self-determination allows the patient to pose a danger to himself.¹⁹⁵ However, Velez stated its analysis was complicated in the case of people with mental illness committed based on parens patriae authority.¹⁹⁶ In such instances, the patient has mental illness and is potentially dangerous to himself and

¹⁸¹ Id. at 731
¹⁸² Id.
¹⁸³ Id.
¹⁸⁴ Id.
¹⁸⁵ Id.
¹⁸⁶ Id.
¹⁸⁷ Id.
¹⁸⁸ Id.
¹⁸⁹ Id.
¹⁹⁰ Id.
¹⁹¹ Id. at 738-739.
¹⁹² Id.
¹⁹³ Id.
¹⁹⁴ Id.
¹⁹⁵ Id.
¹⁹⁶ Id.
necessarily poses a safety risk. Velez declined to broaden the direct threat exception but claimed it had no need to do so. The ADA regulations allow the state to impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities. These requirements must be based on actual risks and not mere speculation or stereotypes about people with disabilities. Velez found adequate justification to support the New Jersey forced medication policy’s differential treatment of parens patriae committed patients.

5. Fundamental Alteration Defense

Proving the governmental program excludes a qualified disabled person is not sufficient, alone, to sustain an ADA violation. The ADA requires the state only to make reasonable accommodations. The state need not fundamentally alter the nature of its services, programs, or activities. Therefore, in response to an ADA challenge, the state may argue invalidating an expansive override provision which enables physicians to treat a committed patient in contravention of a directive would fundamentally alter the state’s programs of civil commitment and involuntary treatment of committed patients.

Hargrave rejected the state’s fundamental alteration argument and held fundamental alteration analysis should focus on the relevant program which was the advance directive program. Vermont argued upholding the lower court’s injunction of the directive abrogation procedure would fundamentally alter Vermont’s programs for involuntary treatment of committed patients and civil commitment generally. Hargrave determined these programs were not the relevant state programs for ADA purposes. Instead, the relevant program was “the statutorily created opportunity to execute [a directive] for health care and have it recognized and followed.” There was no evidence or even assertion the injunction

197 Id.
198 Id.
199 Id.
200 Id.
201 Id.
203 28 C.F.R. 35.130(b)(7).
204 28 C.F.R. 35.130(b)(7); Alexander v. Choate, 469 U.S. 287, 300 & n. 20.
206 Id.
207 Id. at 37.
208 Id. at 38.
209 Id. at 38.
would require the state to fundamentally alter the advance directive program.\textsuperscript{210} 
\textit{Hargrave} based its conclusion on an interpretive regulation which clarifies the ADA requires states to make reasonable modifications in policies or practices to avoid discrimination unless those modifications would constitute a fundamental alteration to the \textbf{relevant} program.\textsuperscript{211}

\textbf{II. AN ADA CRITIQUE OF MENTAL HEALTH DIRECTIVE OVERRIDE PROVISIONS}

This Part illustrates why many mental health directive override provisions violate the ADA. First, Part II(A) describes the typical generic directive override provision which enumerates circumstances allowing clinicians to decline to administer requested care but does not authorize clinicians to force treatment. Part II(B) shows how many mental health directive statutes provide doctors far greater latitude to force treatment on a patient and illustrates why some of these statutes violate the ADA. Part II(C) looks beyond the ADA and explores other arguments for and against more expansive override authority in the mental health context.

\textbf{A. Generic Directive Override Provisions}

The majority of the 25 states that have enacted separate mental health directive statutes grant doctors greater authority to override a mental health directive than do their counterpart generic directive statutes.\textsuperscript{212} The typical generic directive statute only authorizes doctors to override a generic directive in very limited circumstances.\textsuperscript{213} Basically, the typical generic directive override provision allows for declining to follow patient preferences in a directive which are: (1) outside the standard of care, (2) unavailable, (3) medically ineffective, or (4) illegal.\textsuperscript{214}

One influential example of a generic directive override provision is the override provision in the Uniform Health-Care Decisions Act which has been adopted by numerous states.\textsuperscript{215} The Uniform Act only allows clinicians to refuse to implement a directive: 1) for reasons of conscience, or 2) when the directive requires medically ineffective care or treatment contrary to accepted standards.\textsuperscript{216} Basically, these are the same

\begin{footnotesize}
\begin{enumerate}
\item See supra note 5, and accompanying text.
\item See supra note 7, and accompanying text.
\item See supra note 7, and accompanying text.
\item See supra note 7, and accompanying text.
\item UHCDA §7(e-f).
\item Id.
\item Id.
\end{enumerate}
\end{footnotesize}
circumstances authorizing clinicians to refuse to honor contemporaneous treatment choices expressed by patients with capacity.\textsuperscript{217} Each of these circumstances allows clinicians to refuse to administer requested care and do not allow forcing care on a patient.\textsuperscript{218} The Constitution and tort law provide far greater protection to a patient’s right to refuse treatment than they do to a patient’s right to obtain a particular treatment.\textsuperscript{219} Under the Uniform Act, when the clinician refuses to honor the directive, she must notify the patient and make reasonable efforts to transfer the patient to another facility willing to comply with the directive and provide continuing care until transfer.\textsuperscript{220}

In Utah, a provider may only decline to follow a generic directive if the provider believes: (1) the patient or surrogate who made the decision lacks capacity; (2) there is evidence the surrogate's instructions contravene the patient's or for a patient who has always lacked capacity, the surrogate's instructions are inconsistent with the patient's best interests; 3) there is reasonable doubt regarding the status of the person claiming the right to act as default surrogate; 4) or for reasons of conscience.\textsuperscript{221} If the provider declines to follow the directive, the provider must inform the patient or the surrogate of the reasons for refusing to comply, make a good-faith attempt to resolve the conflict, and provide continuing care until the issue is resolved or until transfer to a facility willing to implement the directive.\textsuperscript{222} These enumerated circumstances all focus on protecting patient autonomy, not authorizing clinicians to force treatment to protect the safety of others.\textsuperscript{223} They essentially allow a doctor to refuse to follow the surrogate instruction when there is reason to believe it does not reflect the patient’s wishes.\textsuperscript{224}

Louisiana’s generic directive statute provides even less override authority.\textsuperscript{225} It states any physician who refuses to comply with a generic directive must make a reasonable effort to transfer the patient to another physician.\textsuperscript{226} Moreover, if the healthcare provider's policies preclude compliance with the generic directive, the provider shall take all reasonable steps to transfer the patient to a provider who can effectuate the generic

\begin{footnotesize}
\textsuperscript{217} \textit{Id.}
\textsuperscript{218} \textit{Id.}
\textsuperscript{219} Winick, \textit{supra} note 29, at 70-73.
\textsuperscript{220} UHSDA §7(e-f).
\textsuperscript{221} UT. CODE ANN. 1953 §75-2a-115(4) (2013).
\textsuperscript{222} \textit{Id.}
\textsuperscript{223} \textit{Id.}
\textsuperscript{224} \textit{Id.}
\textsuperscript{225} LA. REV. STAT. §1299.58.7 (2012).
\textsuperscript{226} \textit{Id.}
\end{footnotesize}
OVERRIDE PROVISIONS AND THE ADA

directive. Therefore, Louisiana’s generic directive override provision is primarily concerned with protecting patient autonomy.

B. Mental Health Directive Override Provisions

Unlike generic directive override provisions, the typical mental health directive override provision allows abrogation of treatment refusals, thereby authorizing forced treatment. A patient’s Constitutional and tort law protected rights to bodily integrity and autonomy are squarely implicated when doctors contravene treatment refusals. Mental health directive override provisions are the antithesis of generic directive override provisions. Generic directive override provisions often protect patient autonomy. For example, some allow doctors to refuse to follow surrogate instructions when there is reason to believe surrogate instructions do not reflect patient wishes. The typical generic directive override provision does not threaten a patient’s right to bodily integrity because it allows doctors to refuse to administer requested treatment in certain circumstances. Moreover, generic directive statutes generally require facilities to make efforts to transfer the patient to another facility willing to honor the directive. The typical mental health directive override provision does not require efforts to transfer the patient to a facility willing to honor the directive. Mental health directive override provisions are not primarily concerned with protecting patient autonomy. Rather, they authorize doctors to violate patient autonomy in certain circumstances.

Many mental health directive statutes authorize doctors to override a mental health directive in the following situations: 1) emergencies, 2) pursuant to court order, 3) and in the commitment context. In each of

227 Id.
228 Id.
229 Id.
230 VHA Report, supra note 5, at 6-7.
231 Winick, supra note 29, at 70-73.
232 VHA Report, supra note 5, at 6-7.
233 See supra Part II(A).
234 See supra Part II(A).
235 VHA Report, supra note 5, at 6-7
236 UHCPA §7(e-f).
237 VHA Report, supra note 5, at 6-7.
238 Id.
239 Id.
240 Id.
these instances, the doctor administers what he deems to be necessary treatment despite a refusal to such treatment in a directive. This Section explores whether this override formulation violates the antidiscrimination mandate of the ADA.

1. In Emergencies

Generic directive statutes do not typically authorize doctors to override a generic directive in the case of an emergency. Such override authority would not be necessary or appropriate in the end-of-life scenario. Generic directives allow patients to indicate whether they want to prolong life as long as possible, accept artificial nutrition and hydration, or donate their organs. People in comas do not present “emergencies endangering safety” the way patients suffering from an acute psychotic episodes may.

Many states with separate mental health directive statutes authorize a doctor to treat in contravention of a mental health directive in an emergency. Typically, these mental health directive statutes do not require a court order or administrative hearing for physicians to forcibly medicate a patient in contravention of his directive in an emergency. For example, Hawaii’s statute lists “cases of emergency when the principal poses an imminent threat to the safety of self or others” as one of the instances in which a clinician may treat a principal in contravention of the principal's mental health directive. Hawaii, like most other states, does not require an administrative hearing or court order when a physician administers medication in an emergency in contravention of a mental health directive.

Moreover, these states authorize treatment in contravention of the mental health directive in cases of emergency, even if the patient is not committed. For example, Utah authorizes doctors to administer intrusive mental health treatment contrary to a directive in two separate scenarios:

241 Id.
242 UHCDA §7(e-f); VHA Report, supra note 5, at 6-7.
243 Backlar, supra note 4, at 261-62.
244 UHCDA §7 (e-f).
246 VHA Report, supra note 5, at 6-7.
247 Id.
248 HAW. REV. STAT. §327G-8.
249 Id.
250 VHA Report, supra note 5, at 6-7.
when the patient is committed, or in emergencies.\textsuperscript{251} For patients who have not been committed, there has never been a court determination the patient posed a danger to self or others or was gravely disabled.\textsuperscript{252}

A few states impose an additional requirement on clinicians before treating patients in contravention of directives in emergencies.\textsuperscript{253} For example, Louisiana and Texas authorize a clinician to medicate a patient in contravention of her mental health directive when there is an emergency and the patient's directive has not been effective in reducing the severity of the behavior that caused the emergency.\textsuperscript{254}

The mental health directive statutes differ in how and whether they define "emergency."\textsuperscript{255} Louisiana defines emergency to be an instance when the patient presents an imminent and significant danger of physical harm to self or others.\textsuperscript{256} Similarly, Kentucky expressly authorizes a clinician to override treatment refusals in a mental health directive when there is an "emergency endangering a person's life or posing a serious risk to physical health."\textsuperscript{257}

Idaho, North Carolina, Oregon, Utah, Tennessee, and Illinois define emergency much broader.\textsuperscript{258} These states authorize clinicians to treat in contravention of a mental health directive in cases of emergency endangering life or health,\textsuperscript{259} but do not clarify which emergencies endanger health.\textsuperscript{260} If "emergency endangering health" is interpreted to include any episode endangering mental health, most acute mental illness episodes potentially justify clinicians in ignoring mental health directives.\textsuperscript{261} This is because untreated mental illness episodes often result in deterioration of cognitive functions and, if left untreated, may ultimately lead to psychosis.\textsuperscript{262} A broad interpretation of these states' override
provisions potentially authorizes doctors to override mental health directives any time doing so would prevent deterioration of cognitive functions.\textsuperscript{263}

Still other states such as Texas\textsuperscript{264} do not define what constitutes an emergency justifying a clinician in overriding a mental health directive. Washington also does not define emergency.\textsuperscript{265} However, Washington adds an additional requirement.\textsuperscript{266} Washington requires a clinician to treat in accordance with a mental health directive to the fullest extent possible unless the clinician finds: 1) there is an emergency and 2) compliance would endanger any person's life or health.\textsuperscript{267} Arguably, endangering mental health would be sufficient.\textsuperscript{268}

ADA Analysis

States which authorize a doctor to override a mental health directive in “emergencies” when they do not allow a doctor to override a generic directive in “emergencies” arguably violate the ADA.\textsuperscript{269} As indicated above, a person with a mental illness is a qualified individual with a disability under the ADA.\textsuperscript{270} Blanket authorization to doctors to abrogate the directives of people with mental illness in emergencies when doctors do not have such authority to ignore the advance wishes of other people excludes one group of people (those with mental illness) from a service, program, or activity of the state.\textsuperscript{271} Hargrave indicates the relevant program is the state’s statutory program authorizing people to form advance directives and requiring doctors to honor directives.\textsuperscript{272} Arguably, states which authorize abrogation of directives for emergencies only in the mental health context discriminate due to an individual’s disability: mental illness.\textsuperscript{273}

The key question is whether the direct threat exception exempts states from the ADA in cases of emergencies.\textsuperscript{274} The ADA defines direct

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{263} See supra note 22 and accompanying text.
\item \textsuperscript{264} TEX. CODE ANN. §137.008.
\item \textsuperscript{265} WASH. REV. CODE §71.32.150.
\item \textsuperscript{266} Id.
\item \textsuperscript{267} Id.
\item \textsuperscript{268} Id.
\item \textsuperscript{269} VHA Report, supra note 5, at 6-7.
\item \textsuperscript{270} 42 U.S.C. §12131(2).
\item \textsuperscript{271} Hargrave v. Vermont, 340 F.3d 27, 37 (2003).
\item \textsuperscript{272} Id. at 37-39.
\item \textsuperscript{273} 29 C.F.R. 1630.2(h); EEOC v. JB Hunt Transport, Inc., 321 F.3d 69, 74 (2d Cir. 2003).
\item \textsuperscript{274} 42 U.S.C. §12182(b)(3).
\end{itemize}
\end{footnotesize}
threats as those presenting significant risks to the health or safety of others that cannot be eliminated by the modification of policies, practices, or procedures or by the provision of auxiliary aids or services. In determining whether an individual poses a direct threat, the state must make an individualized assessment, based on reasonable judgment relying on current medical knowledge.

Arguably, the direct threat exception does not exempt from the ADA nondiscrimination mandate many of the statutes allowing abrogation of mental health directives in emergencies. For example, in Idaho, North Carolina, Oregon, Utah, Tennessee, and Illinois clinicians may abrogate a mental health directive in cases of emergency endangering life or health of the patient or others. These states do not clarify whether such emergencies may include emergencies potentially affecting the patient’s mental health. Acute mental health episodes which could result in the deterioration of the patient’s cognitive functions admittedly endanger the patient’s mental health but do not necessarily pose a direct threat to the health or safety of others. First, acute episodes which may lead to deterioration of cognitive functions do not necessarily pose a threat to the physical health and safety of the patient. The ADA direct threat exception refers to situations which endanger physical health. The implementing regulations require an individualized assessment as to the nature, duration, and severity of the risk and the probability that potential injury will actually occur. Potential injury refers to physical injury. Therefore, emergencies which only endanger the mental health of the patient but not physical health or safety of anyone do not fall under the direct threat exception of the ADA.

Second, Hargrave concluded the defendants failed to demonstrate people committed because they posed a danger to themselves, as opposed to others, fell under the direct threat exception. Hargrave stated the direct

275 Id.
276 28 C.F.R. 35.139.
277 42 U.S.C. §12182(b)(3).
278 See supra notes 258-260 and accompanying text.
279 See supra notes 258-260 and accompanying text.
281 See supra Part I(A)(3) (setting forth commitment criteria requiring dangerousness which would not allow commitment of patients who only present a risk of injury to their own mental health, not the safety of themselves or others).
283 28 C.F.R. 35.139.
284 Id.
285 Id.
286 Hargrave, 340 F.3d at 36.
threat defense requires the patient to pose a risk of harm to others.\textsuperscript{287} Many state override provisions authorize abrogation of a mental health directive if there is an emergency in which the patient poses a threat to her own health.\textsuperscript{288} Such situations do not necessarily pose a risk of harm to others.\textsuperscript{289} Pursuant to \textit{Hargrave}, differential treatment to people with mental illness is not justified under the direct threat exception unless there is an individualized assessment the emergency presents a risk of physical harm to others.\textsuperscript{290}

However, there are valid arguments the direct threat exception exempts a state program which authorizes abrogation of only mental health directives in emergencies.\textsuperscript{291} In \textit{Velez}, plaintiffs argued the direct threat exception did not justify the state’s differential treatment of people committed based on \textit{parens patriae} authority.\textsuperscript{292} Although \textit{Velez} acknowledged an inherent difference between situations in which patients pose a danger to themselves and situations in which patients pose a danger to others, \textit{Velez} concluded the ADA analysis was complicated in the \textit{parens patriae} commitment scenario.\textsuperscript{293} \textit{Velez} was reluctant to broaden the direct threat exception but concluded there would be absurd results if danger to oneself did not fall under the purview of the direct threat exception.\textsuperscript{294}

More importantly, \textit{Velez} stated the ADA regulations foresaw general safety concerns enabling the state to impose safety requirements necessary for the safe operation of programs, based on actual risks and not speculation or stereotypes.\textsuperscript{295} When a physician, trained in mental illness, overrides a directive because a patient is in the midst of an emergency, the physician necessarily makes an individualized determination based on actual risks, not speculation, stereotypes, or generalizations.\textsuperscript{296} The direct threat exception requires an individualized assessment based on reasonable judgment, relying on current medical knowledge.\textsuperscript{297} There is no person better able to make this individualized assessment based on medical knowledge than the psychiatrist, treating the patient, deciding whether the patient presents an emergency.\textsuperscript{298}

\begin{thebibliography}{99}
\bibitem{287} Id.
\bibitem{288} See \textit{supra} notes 242-268 and accompanying text.
\bibitem{289} See \textit{supra} notes 258-263 and accompanying text.
\bibitem{290} \textit{Hargrave}, 340 F.3d at 36.
\bibitem{291} See \textit{infra} notes 292-303 and accompanying text.
\bibitem{292} \textit{Velez}, 974 F.Supp.2d at 738-39.
\bibitem{293} Id.
\bibitem{294} Id.
\bibitem{295} 28 C.F.R. 35.130(h).
\bibitem{296} Id.
\bibitem{297} Id.; \textit{Olmstead v. L.C.}, 527 U.S. 581, 610 (J. Kennedy, concurring) (1999) (resolving

\end{thebibliography}
Moreover, states may argue preventing doctors from overriding mental health directives in emergencies fundamentally alters state emergency detention and screening programs. Typically, commitment statutes authorize involuntary emergency admission and evaluation without a full adjudicatory commitment hearing. The doctor at the receiving facility examines the person to determine if emergency treatment is necessary to protect the safety of the person or others. Requiring a clinician to honor a patient’s treatment refusal in a mental health directive when emergency treatment is necessary to protect the safety of the patient or others fundamentally alters the state’s program for emergency detention and screening. Therefore, states may argue provisions authorizing doctors to override mental health directives in emergency situations do not violate the ADA because they fall under the fundamental alteration defense. However, Hargrave rejected this fundamental alteration argument and held that the analysis should focus on the relevant program, the advance directive program, not the commitment program.

2. Pursuant to Court Order

Some states, such as Illinois, Michigan, and Kentucky, grant statutory authorization to clinicians to override a patient’s wishes expressed in a mental health directive pursuant to a court order. Generic directive statutes do not give this override authority. This type of override provision fails to give guidance to the court as to the criteria for issuing an order allowing abrogation of a directive. Need the patient be dangerous to others? Is it sufficient if the patient is dangerous to himself? What if the patient is not truly dangerous but treatment would help the patient’s condition improve? The override provision also fails to specify how recent the court order must be. Would a commitment order authorizing forced treatment be sufficient to override a mental health directive refusing such treatment if the court order was issued six months

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300 See e.g., Fla. STAT. §394.463(2) (2013).
301 Id. §394.463.
302 Hargrave, 340 F.3d at 37.
303 Id.
304 See e.g., ILL. COMP. STAT. ANN. §75 43/45; KY. REV. STAT. ANN. §202A .426; MI. COM. L. ANN. §700.5511.
305 VHA Report, supra note 5, at 6-7.
306 See supra note 304 and accompanying text.
prior to the date of the proposed forced treatment? Hargrave concluded the direct threat exception was not applicable when a court’s initial dangerousness determination was made at the time of commitment but the state failed to demonstrate every person subject to directive abrogation procedures posed a direct threat to others at the time of directive abrogation.\textsuperscript{307} Hargrave stated after 45 days of commitment and treatment, many patients no longer pose a danger to themselves or others.\textsuperscript{308} Therefore, many mental health directive statutes authorizing directive contravention pursuant to court order are overly broad and do not fall under the direct threat exception.\textsuperscript{309}

Allowing directive abrogation pursuant to court order without providing guidance as to the criteria for issuing such orders and as to the contemporaneity of the court order fails to ensure an individualized dangerousness assessment at the time of directive abrogation.\textsuperscript{310}

3. In Commitment Context

Many mental health directive statutes authorize clinicians to treat a patient in contravention of her mental health directive if the patient is committed\textsuperscript{311} for mental health treatment but impose no other express requirements to justify overriding the directive. For example, pursuant to the Utah and Idaho mental health directive statutes, a physician may subject a patient to intrusive mental health treatment in contravention of the patient's directive if the patient has been committed.\textsuperscript{312} Similarly, in Oregon and Tennessee, a physician can override a mental health directive if the person has been committed in a state facility.\textsuperscript{313}

Other states, like Texas only authorize mental health treatment in contravention of a directive if the patient is under a commitment order and treatment is authorized pursuant to the mental health code.\textsuperscript{314} In this instance, merely being committed is insufficient grounds to support treatment in contravention of a mental health directive.\textsuperscript{315} The patient must also meet the requirements for authorizing forced treatment articulated in a

\textsuperscript{307} Hargrave, 340 F.3d at 37.
\textsuperscript{308} Id.
\textsuperscript{309} Id.
\textsuperscript{310} Id.
\textsuperscript{311} In re Rosa M., 597 N.Y.S.2d 544 (1991) (asserting absent an overriding state interest, a hospital must respect patient's treatment refusal in directive).
\textsuperscript{312} UT. CODE ANN. §62A-15-1003; ID. CODE ANN. §66-609.
\textsuperscript{313} OR. REV. STAT. §127.720; TENN. CODE ANN. §33-6-1006.
\textsuperscript{314} TEX. CODE ANN. §33-6-1006.
\textsuperscript{315} Id.
separate statute.\textsuperscript{316} Similarly, in Minnesota, a physician may administer intrusive mental health treatment contrary to a directive of a committed patient only upon order of the committing court.\textsuperscript{317} Moreover, in Ohio, a physician may override a person’s mental health directive when the person is committed and the committing court allows the treatment.\textsuperscript{318}

ADA Analysis

Authorizing treatment of all patients committed for mental health treatment in contravention of a directive violates the ADA.\textsuperscript{319} People who are committed for mental illness are qualified individuals with a disability.\textsuperscript{320} Allowing abrogation of their directives if they are committed excludes them from the state’s advance directive program based on their disability.\textsuperscript{321} The advance directive program, not the commitment program, is the relevant program for the ADA.\textsuperscript{322} *Hargrave* clarified it is immaterial that directive abrogation only applies to a subset of people with mental illness, people who are committed. Discrimination based on the severity of the disability still violates the ADA.\textsuperscript{323} Moreover, *Hargrave* held the court’s initial dangerousness determination at the time of commitment is insufficient to ensure patients continue to fall under the direct threat exception.\textsuperscript{324} There must be an individualized dangerousness assessment at the time of directive abrogation.\textsuperscript{325} A period of commitment often renders a person no longer dangerous to herself or others.\textsuperscript{326} Under *Hargrave*, the individualized dangerousness assessment must conclude, based on objective medical evidence, the person poses a danger to others.\textsuperscript{327}

However, *Velez* offers support for the conclusion patients who pose a risk of harm to themselves, also pose a general safety risk.\textsuperscript{328} According to *Velez*, ADA regulations allow the state to impose legitimate safety

\begin{itemize}
\item \textsuperscript{316} *Id.*\textsuperscript{.}
\item \textsuperscript{317} *Id.*
\item \textsuperscript{318} *Id.*
\item \textsuperscript{319} *Id.*
\item \textsuperscript{320} *Id.*
\item \textsuperscript{321} *Id.*
\item \textsuperscript{322} *Id.*
\item \textsuperscript{323} *Id.*
\item \textsuperscript{324} *Id.*
\item \textsuperscript{325} *Id.*
\item \textsuperscript{326} *Id.*
\item \textsuperscript{327} *Id.*
\end{itemize}
requirements which must be based on actual risks and not mere speculation or stereotypes.\textsuperscript{329} However, without an individualized dangerousness assessment at the time of directive abrogation, allowing blanket authority to force intrusive mental health treatments on all committed patients violates the ADA.\textsuperscript{330} Even though \textit{Velez} held the forced medication procedures of \textit{parens patriae} committed patients did not violate the ADA, it is important to note there was an individualized dangerousness assessment in an administrative hearing immediately before administration of medication in \textit{Velez}.\textsuperscript{331} Forced medication was not authorized based on the fact of \textit{parens patriae} commitment, without a contemporaneous individualized dangerousness assessment.\textsuperscript{332} After a period of commitment and treatment, many people no longer present a safety risk.\textsuperscript{333} Without an individualized dangerousness assessment at the time of directive abrogation, there is no way to ensure the patient poses an actual risk and the alleged safety requirement of forcing medication is not based on speculation or stereotypes.\textsuperscript{334}

Moreover, allowing directive abrogation of all committed people could include patients a court had determined no longer pose a danger to themselves or others, but are eligible for release and awaiting placement.\textsuperscript{335} \textit{Velez} held these people would not fall under the direct threat exception.\textsuperscript{336} Broad authority to override the mental health directives of all committed people risks forced medication of hospitalized people awaiting placement who no longer pose a risk of harm.\textsuperscript{337}

\textbf{C. Beyond the ADA: Other Considerations}

1. Arguments Supporting More Expansive Override Authority

Mental illness episodes often induce non-therapeutic treatment refusals.\textsuperscript{338} Doctors will have responsibility for caring for "patients who are clinically quite treatable but are allowed to refuse treatment" based on an advance directive.\textsuperscript{339} Honoring non-therapeutic refusals of psychiatric

\textsuperscript{329} \textit{Id.}
\textsuperscript{330} \textit{Id.}
\textsuperscript{331} \textit{Id.}
\textsuperscript{332} \textit{Id.}
\textsuperscript{333} \textit{Hargrave}, 340 F.3d at 37.
\textsuperscript{334} \textit{Id.}
\textsuperscript{335} \textit{Velez}, 974 F.Supp.2d at 738-39.
\textsuperscript{336} \textit{Id.}
\textsuperscript{337} \textit{Id.}
\textsuperscript{338} See Clausen, \textit{supra} note 45, at 5 n. 10.
\textsuperscript{339} Brief of Appellant Respondent at 13 \textit{Hargrave v. Vermont}, 340 F.3d 27 (2003), WL
treatment prevents many treatable mental illnesses from improving.\textsuperscript{340} For some illnesses such as schizophrenia and bipolar disorder, treatment delays produce poorer long-term outcomes.\textsuperscript{341} Treatment delays often result in longer hospital stays and lead to deterioration of the patient's condition.\textsuperscript{342} Medication is often the only way to prevent "chronic assaultive and/or self-injurious behaviors."\textsuperscript{343}

Requiring doctors in state hospitals to follow directives of committed people could alter the state's program of civil commitment.\textsuperscript{344} The Supreme Court has stated medical judgments of responsible state officials hold sway for the appropriate treatment of committed people.\textsuperscript{345} The state will be unable to provide necessary treatment to incompetent, committed persons who have refused such treatment in their mental health directives.\textsuperscript{346} Inflexibly requiring a physician to adhere to a directive does not give deference to the opinion of the responsible treating physician.\textsuperscript{347}

Providing expansive directive override authority benefits mental health patients.\textsuperscript{348} In \textit{Olmstead}, the Supreme Court stated unnecessary institutionalization of people with mental illness is unlawful discrimination under the ADA.\textsuperscript{349} Not allowing a treating physician to override a patient's directive refusing medication could produce longer institutionalization which in itself perpetuates stereotypes and diminishes quality of life of people with mental disabilities.\textsuperscript{350} Not allowing adequate flexibility to override directives which refuse necessary treatment undermines the state's ability to treat patients in a less restrictive setting.\textsuperscript{351}

Physicians are in a unique position when they treat patients who have

\begin{flushleft}
\textsuperscript{32903163.} See Clausen, supra note 45, at 5 n. 13.
\textsuperscript{340} Id.
\textsuperscript{341} Judy Clausen, \textit{Bring Ulysses to Florida: Proposed Legislative Relief for Mental Health Patients}, 16 MARQ. ELDER'S ADVISOR 1, 28 (2014); FLA'S \textit{BAKER ACT: 2013 FACT SHEET DEP'T OF CHILDREN AND FAMILIES}, http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf (stating average stay in state mental health hospital is 1.7 years).
\textsuperscript{343} Brief of Appellant Respondent at 14 Hargrave v. Vermont, 340 F.3d 27 (2003), WL 32903163.
\textsuperscript{344} Id.
\textsuperscript{346} Brief of Appellant Respondent at 15 Hargrave v. Vermont, 340 F.3d 27 (2003), WL 32903163.
\textsuperscript{347} \textit{Olmstead}, 527 U.S. at 610.
\textsuperscript{348} See infra notes 349-351.
\textsuperscript{349} \textit{Olmstead}, 527 U.S. at 582-83.
\textsuperscript{350} Brief of Appellant Respondent at 15 Hargrave v. Vermont, 340 F.3d 27 (2003), WL 32903163.
\textsuperscript{351} \textit{Olmstead}, 527 U.S. at 607 (1999).
\end{flushleft}
mental health directives.\textsuperscript{352} Doctors who disagree with their patients' generic directives are free to transfer their patients to different facilities.\textsuperscript{353} However, providers often administer psychiatric treatment in contravention of a directive in the context of civil commitment.\textsuperscript{354} When physicians treat patients who are involuntarily hospitalized, they do not have the freedom to transfer or discharge the patient if the patient refuses treatment the physician considers essential.\textsuperscript{355} When these physicians are forced to follow the non-therapeutic wishes of patients voiced in directives, the physicians are in the untenable position of depriving patients of necessary and therapeutic treatment.\textsuperscript{356}

There are many ways in which state laws treat mental health directives differently than they do generic directives.\textsuperscript{357} This is because the issues faced at end of life are distinct from the issues implicated in episodic mental illness.\textsuperscript{358} For example, state laws often limit an agent's ability to consent to certain kinds of intrusive mental health treatments such as involuntary commitment, ECT, and psychosurgery.\textsuperscript{359} However, these same states do not place such limits on an agent's ability to consent to non-mental health treatment.\textsuperscript{360} Moreover, the majority of states with separate mental health directive statutes do not allow incapacitated patients to revoke their mental health directives.\textsuperscript{361} However, the counterpart generic directives statutes do not preclude incapacitated patients from revoking generic directives.\textsuperscript{362} Also, many mental health directive statutes state mental health directives expire after a few years, but their counterpart statutes do not provide for automatic expiration of generic directives.\textsuperscript{363} Differences between the end-of-life and episodic mental illness contexts justify states in regulating mental health directives differently than they do generic directives.\textsuperscript{364} Moreover, the ways in which generic and mental health directive statutes differ support more expansive override authority in the mental health

\textsuperscript{352} Brief of Appellant Respondent at 15 Hargrave v. Vermont, 340 F.3d 27 (2003), WL 32903163.
\textsuperscript{353} Miller, supra note 103, at 734-35.
\textsuperscript{354} See supra notes 64-109, and accompanying text.
\textsuperscript{355} Miller, supra note 103, at 734-35.
\textsuperscript{356} Id.
\textsuperscript{357} See supra notes 60-119 and accompanying text.
\textsuperscript{358} See supra note 5 and accompanying text.
\textsuperscript{359} See supra notes 110-119 and accompanying text.
\textsuperscript{360} See supra notes 110-119 accompanying text.
\textsuperscript{361} See supra note 101 and accompanying text.
\textsuperscript{362} Id.
\textsuperscript{363} Brief of Appellant Respondent at 17 Hargrave v. Vermont, 340 F. 27 (2003), WL 32903163.
\textsuperscript{364} Id.
Reasonable authority to override non-therapeutic treatment refusals is pivotal in the effort to encourage the widespread use of mental health directives which will result in the best patient care and support to patient autonomy.\textsuperscript{366} Creating a directive gives the patient a sense of empowerment and encourages self-responsibility.\textsuperscript{367} The planning process is therapeutic because it provides patients opportunities to analyze the patterns of their illnesses and prevent crisis situations.\textsuperscript{368} Patients perceive treatment to be more self-determined because directives allow them to co-author individualized crisis prevention plans.\textsuperscript{369} Without clear, reasonable override authority, doctors will be legitimately concerned non-therapeutic refusals in directives will obstruct their ability to care for patients, respond to emergencies, and prevent danger.\textsuperscript{370} Studies indicate a lack of buy-in and acceptance of mental health directives by clinicians.\textsuperscript{371} This is because doctors do not want directives to prevent them from rendering necessary intervention or court ordered or emergency care.\textsuperscript{372} Reasonable override authority assuages these concerns and encourages the use of directives.\textsuperscript{373}

2. Arguments Against More Expansive Override Authority

When a state gives greater leeway to doctors to override mental health directives than generic directives, the state deters people with mental illness from forming mental health directives.\textsuperscript{374} Why form a directive if it will not be honored? This undermines patient autonomy because mental health directives empower patients to determine care to be administered when they lack capacity.\textsuperscript{375} In fact, permitting people with mental illness to effectuate their treatment preferences may be more important to positive

\textsuperscript{365} Id.
\textsuperscript{366} See infra notes 367-373 and accompanying text.
\textsuperscript{367} Sheetz, supra note 69, at 406-07.
\textsuperscript{368} Winick, supra note 29, at 81-82.
\textsuperscript{370} Brief Appellant Respondent at 17 Hargrave v. Vermont, 340 F.3d 27 (2003), WL 32903163.
\textsuperscript{371} Swanson, supra note 12, at 83.
\textsuperscript{372} Id.
\textsuperscript{373} See infra Part III(A).
\textsuperscript{374} Brief Appellee Petitioner Amicus 4 Hargrave v. Vermont, 340 F.3d 27 (2003), WL 32903163.
\textsuperscript{375} See e.g., FLA. STAT. §765.102 (2013) (setting forth process for patients to create directives to ensure they do not lose rights to self-determination when they lack capacity)
health outcomes than short-term clinical improvement.\textsuperscript{376} Allowing a doctor to override a mental health directive prevents a competent person with a mental disability from having her treatment preferences honored.\textsuperscript{377} People who form mental health directives often have episodic illnesses and have previous experience with treatment, side effects, and outcomes.\textsuperscript{378} The patients are often in the best position to determine the care they need and to refuse care that is ineffective or harmful.\textsuperscript{379}

Mental health treatments are particularly intrusive.\textsuperscript{380} Therefore, obtaining valid informed consent is paramount.\textsuperscript{381} When a doctor overrides a mental health directive, there is no informed consent.\textsuperscript{382} Overriding a treatment refusal is a serious invasion of personal privacy and bodily integrity.\textsuperscript{383}

Providing greater override authority to doctors to nullify the wishes of patients with mental illness undermines parity for mental health treatment.\textsuperscript{384} When states decide to give mental health directives less authority than other forms of advance directives they perpetuate negative stereotypes of people with mental illness.\textsuperscript{385} Ending such stereotypes is one of the goals of the ADA.\textsuperscript{386} Providing more expansive override authority in the mental health context illustrates mental health exceptionalism which is the imposition of burdens on people with mental illness when such burdens are not imposed on other patients.\textsuperscript{387} The typical generic override provision is tailored to protect patient autonomy, but the typical mental health directive override provision seems crafted primarily to allow authority to intrude on patient autonomy.\textsuperscript{388} This sends the message that treatment

\textsuperscript{376} Brief of Appellee Petitioner Amicus at 5 Hargrave v. Vermont, 340 F.3d (2003), WL 32903163.
\textsuperscript{377} Id.
\textsuperscript{378} Id.
\textsuperscript{379} Id.
\textsuperscript{380} See supra Part I(A)(3); \textit{In re Rosa M}, 597 N.Y.S.2d 544 (1991) (requiring hospital to honor rejection of ECT in a directive even after patient lost capacity).
\textsuperscript{383} \textit{Washington v. Harper}, 494 U.S. 210, 221 (1990) (recognizing a significant liberty interest under the due process clause in avoiding unwanted administration of antipsychotic medication.)
\textsuperscript{384} VHA Report, \textit{supra} note 5, at 6.
\textsuperscript{385} Id.
\textsuperscript{387} VHA Report, \textit{supra} note, at 6-7.
\textsuperscript{388} See supra Part II(B).
preferences of people with mental illness deserve less respect than the preferences of everyone else.389

Over the last several decades, laws which exclude civilly committed people or mental health patients from participating in civil rights or legislatively created benefit programs have been found unlawful.390 For example, in Manhattan State Citizens’ Group v. Bass, a federal district court held a law which precluded involuntarily committed people from voting violated the equal protection clause.391 Moreover, a statutory override provision authorizing doctors to abrogate a mental health directive and force treatment on a patient potentially violates the due process clause.392 In Velez the plaintiff alleged the forced medication procedures violated the patients’ due process rights.393 Undoubtedly, individuals have a due process protected liberty interest in avoiding unwanted mental health treatments.394 Due process analysis is outside the scope of this Article. However, abrogation of mental health directives involves forced treatment and implicates the due process clause.395 Due process challenges to forced medication procedures are plentiful.396

III. STRIKING THE RIGHT BALANCE: GUIDANCE FOR LAWMAKERS, PATIENTS, AND DOCTORS

The purpose of this Part is to provide a model advance directive override provision for states to adopt. Part III(A) articulates two recommended override provisions, one from the National Ethics Committee of the Veterans Health Administration, and the other from a preeminent legal scholar. The Committee’s approach fails to allow flexibility to clinicians to respond to emergencies endangering human safety. The scholar’s approach focuses on the wrong issue, the basis for commitment, and fails to require an individualized dangerousness assessment at the time of directive abrogation. Part III(B) sets forth this Article’s model override provision which does not single out people with mental illness. It allows flexibility to respond to emergencies endangering the safety of others and

389 VHA Report, supra note 5, at 6-7.
391 Id. at 11.
392 Velez, 974 F.Supp.2d at 719-729.
393 Id.
395 Id.
complies with the ADA. It also resolves how commitment law and mental health advance directive law should interact. Part III(C) gives advice to patients to better ensure clinicians follow directives. Part III(D) gives guidance to clinicians to help: protect against liability for unlawfully administering forced treatment, strengthen the doctor-patient relationship, and improve patient care.

A. Analysis of Other Proposals

1. National Ethics Committee Recommendation

In a 2008 report, the National Ethics Committee (“Committee”) of the Veterans Health Administration conducted an ethical analysis of state advance directive law. The report revealed the majority of states which have enacted specialized mental health directive statutes give doctors greater leeway to override a mental health directive than to override a generic directive. The report noted these states typically permit doctors to override a mental health directive when the patient has been committed and in emergencies (usually not further defined). However, this same override authority is not provided in the generic directive context. The Committee described the typical generic directive override provision as only allowing generic directive abrogation when patient preferences are: (1) outside the standard of care, (2) unavailable, (3) medically ineffective, or (4) illegal.

The Committee asserted that granting wider latitude to override a mental health directive unjustifiably undermines patient self-determination and autonomy. The report also stated override provisions which respect mental health directives less than generic directives undermine parity for mental health treatment and illustrate mental health “exceptionalism.” The Committee asserted mental health exceptionalism in the context of advance directives is ethically unjustified because no evidence suggests preferences in a mental health directive are less reliable than preferences in a generic one.

The report noted current Veterans Health Administration policy requires doctors to follow mental health directives just as they must follow

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397 VHA Report, supra note 5, at 6-7.
398 Id.
399 Id.
400 Id.
401 Id.
402 Id.
403 Id.
404 Id. at 4.
Override Provisions and the ADA

Therefore, current policy provides no greater override authority in the mental health context.\(^{405}\) The Committee recommended clinicians respect patient preferences expressed in a mental health directive just as they would preferences in a generic directive.\(^{407}\) The report asserted involuntary commitment, emergency situations, or determinations the treatment is essential do not, in and of themselves, justify overriding a mental health directive.\(^{408}\) The Committee refused to identify special circumstances justifying clinicians in overriding a mental health directive.\(^{409}\)

Analysis

The Committee’s refusal to discriminate against people with mental illness is commendable.\(^{410}\) However, the Committee’s approach does not allow adequate flexibility to clinicians to respond to emergencies endangering the health and safety of others.\(^{411}\) Not all such emergencies involve mental health issues.\(^{412}\) For example, a patient with infectious tuberculosis may refuse treatment and quarantine in her directive. If clinicians follow her directive, this contagious patient will endanger the health and safety of staff and other patients.\(^{413}\) Overriding her directive is necessary to protect the health and safety of others.\(^{414}\) Provided there is an individualized risk assessment at the time of directive abrogation, overriding her directive does not violate the ADA.\(^{415}\) This contagious tuberculosis situation falls under the direct threat exception.\(^{416}\) The state may treat this person differently (by abrogating her directive) even though the different treatment is based on her diagnosis.\(^{417}\)

Similarly, mental illness episodes may cause a patient to act in a

\(^{405}\) Id. at 6.

\(^{406}\) Id.

\(^{407}\) Id.

\(^{408}\) Id.

\(^{409}\) Id.

\(^{410}\) Id.


\(^{412}\) See e.g., Hargrave, 340 F.3d at 38 (not precluding authorization to override any incompetent person's directive when compliance would substantially burden state interests).

\(^{413}\) 42 U.S.C. §12182(b)(3).

\(^{414}\) Id.

\(^{415}\) Hargrave, 340 F.3d at 36.

\(^{416}\) 42 U.S.C. §12182(b)(3).

\(^{417}\) Id.
way which presents imminent risk to the health and safety of others. If such a patient formed a mental health directive refusing all intervention, clinicians need authority to override the directive to respond to an emergency endangering the health and safety of others.

The Committee recommends the typical generic directive override provision in all contexts and declines to identify circumstances justifying directive abrogation in the mental health context. This typical generic directive override provision does not contemplate mental illness episodes or other forms of emergencies which endanger the health and safety of others. Rather, the typical generic directive override provision focuses on end-of-life scenarios and only allows directive abrogation for patient preferences for unacceptable, ineffective, unavailable, or illegal treatments. This generic directive override provision allows a doctor to refrain from providing certain requested treatments. It does not allow a clinician to force intervention on a patient in contravention of a directive, even when intervention is necessary to respond to an emergency endangering the health and safety of others. In this way, the Committee recommendation risks human safety. Some of these emergencies endangering human safety involve mental health; some, such as the tuberculosis scenario described above, do not. The ADA direct threat exception allows states to craft directive override provisions which are necessary to protect against risks to the health and safety of others. States should adopt this Article’s approach which complies with the ADA and allows clinicians to respond to emergencies endangering the health and

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418 See e.g., Tuten, 84 F.3d at 1063; Moraes v. Horizons of the Treasure Coast, Inc., 2013 WL 4009438 (S.D. Fla.) (episode causing patient to drive dangerously and later commit suicide).
420 VHA Report, supra note, at 6-7.
421 Id.
422 Id.
423 Id.
424 Id.
425 Id.
safety of others.\textsuperscript{428}

2. One Legal Scholar’s Recommendation

In 1996, Professor Bruce Winick authored an article exploring the potential for mental health directives to change society’s perception of involuntary commitment and forced treatment issues from adversary disputes needing judicial resolution to advance planning opportunities.\textsuperscript{429} In 1996, comprehensive statutory codes regulating mental health directives did not exist as they do today.\textsuperscript{430} He identified instances in which he believed the state should authorize clinicians to override a mental health directive.\textsuperscript{431} He recognized the Constitution and tort law provide far greater protection to a patient’s right to refuse treatment than they do to a patient’s right to obtain a particular treatment.\textsuperscript{432} Therefore, clinicians should have greater latitude to override a mental health directive consenting to treatment than one refusing treatment.\textsuperscript{433} Clinicians should not be required to administer treatment to which a patient consented in a directive when the treatment is unlawful, unapproved by the FDA, in excess of the patient’s financial resources, or banned by the clinician’s professional ethics.\textsuperscript{434} Essentially, doctors should have override authority (whether for a mental health or generic directive) when the directive consents to clinically inappropriate or unethical treatment or treatment, the administration of which in the circumstances, would violate informed consent principles.\textsuperscript{435}

When the state allows doctors to force treatment or hospitalization on a patient whose directive refuses such treatment, the patient’s significant due process and statutory rights to refuse medical treatment are implicated.\textsuperscript{436} Professor Winick asserts when the state interest in overriding a mental health directive is based on \textit{parens patriae} commitment authority, the patient’s right to bodily integrity and autonomy should prevail.\textsuperscript{437} Doctors should not be able to override a mental health directive based merely on the fact the patient was committed based on \textit{parens patriae} grounds.\textsuperscript{438} However, he asserts a mental health directive should not control

\begin{thebibliography}{99}
\bibitem{428} See \textit{supra} Part III(A).
\bibitem{429} Winick, \textit{supra} note 29, at 60.
\bibitem{430} VHA Report, \textit{supra} note 5, at 14-15.
\bibitem{431} Winick, \textit{supra} note 29, at 70-72
\bibitem{432} \textit{Id.} at 71, 72
\bibitem{433} \textit{Id.} at 70.
\bibitem{434} \textit{Id.} at 70.
\bibitem{435} \textit{Id.} at 72.
\bibitem{436} \textit{Id.} at 73.
\bibitem{437} \textit{Id.}
\bibitem{438} \textit{Id.} at 73-74.
\end{thebibliography}
in situations in which the state interest in hospitalization or forced treatment is based on the state’s police power.\textsuperscript{439} He defines police power commitment as commitment to prevent the patient’s suicide or harm to others.\textsuperscript{440} The patient’s autonomy interest supporting enforcing the mental health directive refusing hospitalization and treatment does not outweigh the state’s interest in preventing suicide or protecting other people’s safety.\textsuperscript{441} He recommends commitment and forced treatment laws based on police power interests should prevail over preferences in mental health directives.\textsuperscript{442} However, when commitment is based only on \textit{parens patriae} authority, treatment and commitment should only occur in the absence of a mental health directive refusing hospitalization or treatment.\textsuperscript{443}

Analysis

Professor Winick published his article before the \textit{Hargrave} and \textit{Velez} decisions.\textsuperscript{444} His approach addressed due process concerns, not ADA concerns.\textsuperscript{445} In light of \textit{Hargrave} and \textit{Velez}, without an individualized dangerousness assessment at the time of directive abrogation, Professor Winick’s approach raises ADA concerns.\textsuperscript{446} Under the ADA, a person with mental illness committed on police power grounds is a “qualified individual with a disability.”\textsuperscript{447} Professor Winick recommends an override provision allowing clinicians to abrogate mental health directives of patients committed based on police power interests.\textsuperscript{448} Such an override provision excludes these committed individuals from the state program allowing patients to determine healthcare to be administered when they lack capacity.\textsuperscript{449} When individuals who have been committed for police power interests are subject to directive abrogation, when other people are not, their exclusion from the state advance directive program is due to the disability of mental illness.\textsuperscript{450}

Admittedly, the ADA does not require public entities to allow individuals to participate in programs where the individuals pose a direct

\textsuperscript{439} Id.
\textsuperscript{440} Id.
\textsuperscript{441} Id.
\textsuperscript{442} Id.
\textsuperscript{443} Id.
\textsuperscript{444} Hargrave, 340 F.3d at 27; Velez, 974 F.Supp.2d at 705.
\textsuperscript{445} Winick, \textit{supra} note, at 70-73.
\textsuperscript{446} Hargrave, 340 F.3d at 36-37; Velez, 974 F.Supp.2d at 732.
\textsuperscript{447} See \textit{supra} Part I(B).
\textsuperscript{448} Winick, \textit{supra} note 29, at 70-73.
\textsuperscript{449} Hargrave, 340 F.3d at 37-38.
\textsuperscript{450} \textit{Id.} at 36.
threat to the health or safety of others.\textsuperscript{451} However, \textit{Hargrave} clarified the fact of police power commitment does not, in and of itself, render the direct threat exception applicable.\textsuperscript{452} \textit{Hargrave} required the state to demonstrate every person subject to advance directive abrogation posed a direct threat to others sufficient to exclude the person from the ADA under the direct threat exception.\textsuperscript{453} Vermont neglected to require an individualized assessment of the danger the individual posed at the time of advance directive abrogation.\textsuperscript{454} Therefore, Professor Winick’s approach would violate the ADA unless the override provision required an individualized dangerousness assessment at the time of directive abrogation.\textsuperscript{455}

Moreover, Professor Winick defines police power commitment to include commitment to prevent the patient’s suicide.\textsuperscript{456} There is no consensus that \textit{parens patriae} commitment includes commitment to prevent suicide.\textsuperscript{457} Presumably, under his definition, \textit{parens patriae} commitment does not include commitment to prevent suicide but commitment in situations when mental illness has caused the person to be unable to provide for her own basic needs (i.e. gravely disabled).\textsuperscript{458} Arguably, under \textit{Hargrave}, Professor Winick’s approach allowing for directive abrogation to prevent suicide would not fall under the ADA’s direct threat exception.\textsuperscript{459} \textit{Hargrave} concluded commitment based on a court determination the individual posed a danger to \textit{himself} would not necessarily fall under the direct threat exception which requires the person to pose a danger to \textit{others}.\textsuperscript{460}

However, assuming an individualized dangerousness assessment at the time of directive abrogation, \textit{Velez} arguably authorizes directive contravention if the person presents a suicide risk.\textsuperscript{461} \textit{Velez} defines \textit{parens patriae} commitment as commitment of people with mental illness who are potentially dangerous to themselves.\textsuperscript{462} Therefore, under \textit{Velez}, \textit{parens patriae} commitment includes commitment based on a risk of suicide.\textsuperscript{463} This definition is distinguished from Professor Winick’s definition because

\textsuperscript{451} 42 U.S.C. §12182(b)(3).
\textsuperscript{452} \textit{Hargrave}, 340 F.3d at 37.
\textsuperscript{453} \textit{Id}.
\textsuperscript{454} \textit{Id}.
\textsuperscript{455} Winick, \textit{supra} note 29, at 70-73.
\textsuperscript{456} \textit{Id}.
\textsuperscript{457} \textit{See supra} Part I(A)(3).
\textsuperscript{458} Winick, \textit{supra} note 29, at 70-73.
\textsuperscript{459} \textit{Hargrave}, 340 F.3d 36.
\textsuperscript{460} \textit{Id}.
\textsuperscript{461} \textit{Velez}, 974 F.Supp.2d at 738-39.
\textsuperscript{462} \textit{Id}.
\textsuperscript{463} \textit{Id}.
he states police power commitment includes commitment to prevent suicide.\textsuperscript{464} \textit{Velez} acknowledges the direct threat exception \textit{technically} requires the individual pose a risk to others, not just herself.\textsuperscript{465} However, \textit{Velez} stated the analysis is complicated in the case of mental illness based on \textit{parens patriae} authority because people who pose a danger to themselves pose a safety risk to others.\textsuperscript{466}

Therefore, Professor Winick’s approach focuses on the wrong issue, the basis for the original commitment.\textsuperscript{467} His approach allows for mental health directive abrogation based on police power commitment, not \textit{parens patriae} commitment.\textsuperscript{468} \textit{Velez} clarifies people with mental illness who pose a danger to themselves also present a safety risk to others.\textsuperscript{469} The key to crafting an ADA compliant override provision which also allows flexibility to protect human safety is to require an individualized dangerousness assessment at the time of directive abrogation.\textsuperscript{470} Allowing a physician to override a directive based only on a court determination of dangerousness to self or others, at the time of the original commitment violates the ADA.\textsuperscript{471} Admittedly, at the time of the original commitment, the person was adjudicated dangerous to herself or others.\textsuperscript{472} However, after a period of hospitalization, the committed patient likely is no longer dangerous to herself or others.\textsuperscript{473} Without an individualized dangerousness assessment at the time of directive abrogation, people may be subject to forced treatment in contravention of directive when they are not dangerous.\textsuperscript{474}

\textit{B. Legislative Proposal: a Model Override Provision}

\textit{Hargrave} was sensitive to the fact the ADA’s preemption of the Vermont statute might have consequences not contemplated by the legislature and which could burden healthcare professionals.\textsuperscript{475} \textit{Hargrave} refused to preclude legislation which avoids singling out people with mental illness.\textsuperscript{476} For example, revisions to state advance directive law which

\begin{itemize}
  \item \textsuperscript{464} Winick, supra note 29, at 70-73.
  \item \textsuperscript{465} \textit{Velez}, 974 F.Supp.2d at 738-39.
  \item \textsuperscript{466} Id.
  \item \textsuperscript{467} Winick, supra note 29, at 70-73.
  \item \textsuperscript{468} Id.
  \item \textsuperscript{469} \textit{Velez}, F.Supp.2d at 738-39.
  \item \textsuperscript{470} \textit{Hargrave}, 340 F.3d at 36.
  \item \textsuperscript{471} Id.
  \item \textsuperscript{472} Id.
  \item \textsuperscript{473} Id.
  \item \textsuperscript{474} See supra Part I(A)(3) (illustrating this would violate the due process clause and other statutes in common law doctrines).
  \item \textsuperscript{475} \textit{Hargrave}, 340 F.3d at 38.
  \item \textsuperscript{476} Id.
\end{itemize}
increase the competency threshold for executing an advance directive or which allow overriding any incompetent person’s directive when compliance with it substantially burdens state interests may be ADA compliant.\textsuperscript{477}

The approach below balances patients’ rights of autonomy with the state’s interest in preventing risks to the health and safety of others.\textsuperscript{478} This Article’s approach responds to Hargrave’s invitation to craft an advance directive override provision which is ADA compliant.\textsuperscript{479} First, states should use the same override provision for all advance directives.\textsuperscript{480} Such an approach meets Hargrave’s challenge to craft an override provision that refuses to single out people with mental illness.\textsuperscript{481} States should adopt the following override provision:

\begin{quote}
Health care professionals who provide treatment to a patient shall comply with the desires expressed in the patient’s advance directive (hereinafter “directive”), including the desires expressed by the patient’s designated agent. If one or more of the following apply to a patient instruction contained in a directive (including those expressed by her agent), the health care professional is not bound to follow that instruction, but shall follow the patient’s other instructions as expressed in the directive or by the agent:

1) in the opinion of the healthcare professional, compliance with the instruction is inconsistent with generally accepted health care standards applicable to the health care provider or institution,

2) in the opinion of the healthcare professional, the requested treatment is medically ineffective,

3) compliance with the instruction is contrary to an institutional policy which is expressly based on reasons of conscience, and the policy was timely communicated to the patient or to the designated agent,

4) compliance with the instruction would violate the healthcare professional’s conscience,\textsuperscript{482} or

5) in the opinion of the healthcare professional, following the instruction poses a direct threat to the health or safety of others. The healthcare professional must make a written finding in the patient’s medical records explaining her determination that following the instruction poses a
\end{quote}

\textsuperscript{477}Id.
\textsuperscript{478}40 U.S.C. §12182(b)(3).
\textsuperscript{479}Id.
\textsuperscript{480}VHA Report, supra note 5, at 6-7.
\textsuperscript{481}Hargrave, 340 F.3d at 38.
\textsuperscript{482}UHCDA §7(e-f).
direct threat to the health or safety of others. Authority to refuse to follow an instruction based on a healthcare professional’s determination of a direct threat expires after 72 hours. After 72 hours, contravention of the instruction must be authorized by court order as follows. A court may grant an order authorizing contravention of the instruction based on its determination that following the instruction poses a direct threat to the health or safety of others. Such direct threat means there is a significant risk to the health or safety of others that cannot be eliminated by modification of policies, practices, or procedures or by the provision of auxiliary aids or services. In determining whether an individual poses a direct threat to the health or safety of others, there must be an individualized assessment, based on reasonable judgment, relying on current medical knowledge or on the best available objective evidence to ascertain the nature, duration, and severity of the risk, the probability potential injury will actually occur, and whether reasonable modifications in policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk. A court determination that following the instruction presents a direct threat to the patient’s health or safety may be evidence supporting a determination that the patient presents a direct threat to the health or safety of others. Contravention of an instruction under this subsection 5 must also comply with any additional requirements imposed by law.\footnote{483}

If a healthcare professional declines to follow an instruction for reasons stated in subsections 1-4, but not 5, the institution shall
1) promptly inform the patient, if possible, and any designated agent,
2) provide continuing care to the patient until a transfer can be effected; and
3) unless the patient or designated agent refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution willing to comply with the instruction.

Explanation

This override provision allows flexibility to clinicians to respond to emergencies which threaten the health or safety of others, regardless of whether these emergencies implicate mental health issues.\footnote{484} The model provision meets the Hargrave challenge.\footnote{485} If refuses to single out people

\footnote{483} 28 C.F.R. 35.139.
\footnote{484} 42 U.S.C. §12182(b)(3).
\footnote{485} Hargrave, 340 F.3d at 38.
with mental illness for differential treatment.\textsuperscript{486} It also meets the National Ethics Committee challenge; it refuses to engage in mental health exceptionalism.\textsuperscript{487} The override provision does not mention \textit{parens patriae} or police power commitment or any other issue which primarily involves people with mental illness;\textsuperscript{488} It provides the same protections to patient autonomy for people with mental illness as it provides to all other people.

The model approach protects the health or safety of others better than the Committee approach because it allows healthcare professionals to respond to emergency situations to prevent imminent risks to human safety.\textsuperscript{489} The Committee’s recommendation fails to adequately protect human safety because it recommends the standard generic directive override provisions for all situations.\textsuperscript{490} The Committee describes the typical generic directive override provision as only allowing contravention of directives which request treatment that is medically unacceptable, ineffective, unavailable, or unethical; this does not expressly authorize providers to respond to emergencies which endanger the health or safety of others.\textsuperscript{491} The model approach adopts the Uniform Act’s override provision because it is probably the most influential generic directive override provision.\textsuperscript{492} Then the model approach adds override authority to respond to emergencies endangering the health or safety of others.

Moreover, the model approach provides needed guidance on the interaction between mental health directive law and commitment law.\textsuperscript{493} The model approach complies with the typical state involuntary commitment law because it authorizes doctors to administer emergency treatment on a patient based on the doctor’s determination the patient is dangerous.\textsuperscript{494} However, this authority usually expires after 72 hours.\textsuperscript{495} Continued hospitalization and treatment must be authorized by a court. The 72 hour time frame is necessary to comply with commitment law because it empowers doctors to respond to dangerous emergencies by authorizing emergency intervention without a court order, based only on the doctor’s determination for a short period of time.\textsuperscript{496} This 72 hour timeframe provides sufficient time for the facility to obtain court authority to continue

\begin{itemize}
    \item \textsuperscript{486} \textit{Id.}
    \item \textsuperscript{487} VHA Report, \textit{supra} note 5, at 6-7.
    \item \textsuperscript{488} See \textit{supra}, Part I(A)(3).
    \item \textsuperscript{489} \textit{Id.}
    \item \textsuperscript{490} \textit{Id.}
    \item \textsuperscript{491} \textit{Id.}
    \item \textsuperscript{492} UHCDA §7(e-f).
    \item \textsuperscript{493} Advising the Elderly Client, \textit{supra} note 37, at §33:18.
    \item \textsuperscript{494} See \textit{supra} Part I (A).
    \item \textsuperscript{495} See \textit{e.g.}, FLA. STAT. §394.463 (2013).
    \item \textsuperscript{496} \textit{Id.}
\end{itemize}
After the 72 hour timeframe, continued treatment without consent must be authorized by a court. The model approach provides courts guidance as to when they may issue such orders authorizing directive abrogation. Some jurisdictions may impose commitment criteria which are more stringent than the dangerousness assessment imposed by ADA direct threat exception. For example, the jurisdiction may impose an overt act requirement evidencing the patient’s dangerousness. The model override provision addresses these situations in which the commitment criteria may be more stringent than the direct threat exception criteria. It clarifies that directive contravention must also comply with any additional applicable legal requirements.

The model approach protects patient autonomy more than many statutes which authorize mental health directive abrogation when patients are committed (without requiring an individualized risk assessment at the time of directive abrogation), when there is an emergency (without further defining emergency and potentially covering situations which do not fall under the direct threat exception), and when there is a court order (without providing guidance as to when courts may issue such orders). This Article’s model focuses on the key issue under the ADA: the individualized risk to human safety assessment at the time of directive abrogation. The model provision mirrors ADA regulations explaining the direct threat exception. The model approach recognizes that sometimes a court determination that a patient presents a direct threat to her own health or safety is evidence supporting the conclusion she presents a direct threat to others. This will not always be the case. For example, following the directive of a terminally ill patient whose directive refuses artificial nutrition and hydration endangers the health or safety of that patient – it hastens death. However, following the directive does not, in the end-of-life scenario, endanger the health or safety of other people.

However, in other situations, a court finding that following the directive endangers the patient is evidence that following the directive endangers others. For example, following the directive of a tuberculosis patient whose directive refuses treatment and quarantine endangers the

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497 Id.
498 Id.
499 See supra Part III(B).
500 See e.g., KAN. STAT. ANN. §59-2946(f) (2013).
501 Id.
502 See supra Part II(B).
503 Hargrave, 340 F.3d at 36.
504 28 C.F.R. 35.139.
51 OVERRIDE PROVISIONS AND THE ADA

patient.\textsuperscript{506} A court finding to this effect is evidence that following the directive endangers others.\textsuperscript{507} Similarly, following the directive of a suicidal patient whose directive refuses hospitalization and treatment endangers the patient. A court finding to this effect is evidence that following the directive endangers others.\textsuperscript{508} \textit{Velez} noted, in the case of mental illness, the line between endangering the self and endangering others blurs because of the unpredictable nature of mental illness episodes.\textsuperscript{509}

The recommended approach protects against abuse and safeguards patient autonomy better than Professor Winick’s approach which recommends authorizing mental health directive abrogation for police power commitment but not \textit{parens patriae} commitment.\textsuperscript{510} Professor Winick fails to expressly require an individualized assessment of risk to the health or safety of others at the time of directive abrogation.\textsuperscript{511} The fact a patient is committed under police power authority does not necessarily mean she presents a risk of harm to others at the time of directive abrogation.\textsuperscript{512} Professor Winick’s approach as well as the approach of several state mental health directive statutes fails to recognize many committed patients, after a period of commitment and treatment may no longer present a direct threat to the health or safety of others.\textsuperscript{513}

\textbf{C. Practical Advice for Patients}

Whether patients use directives to refuse or consent to treatment, patients can better ensure courts and doctors follow their wishes if patients adhere to the following guidance.

1. Obtain Physician Attestation of Patient Capacity

Generally, generic directive statutes and mental health directive statutes expressly presume the principal had capacity at the time of directive execution.\textsuperscript{514} Patients should not rely on this presumption. Instead, patients should obtain a physician attestation the patient possessed capacity at the time of directive formation. This extra effort will help ensure doctors and courts follow the directive. A physician attestation will help preclude people

\textsuperscript{506} Id.
\textsuperscript{507} Id.
\textsuperscript{508} Id.
\textsuperscript{509} Id.
\textsuperscript{510} Winick, supra note 29, at 70-73.
\textsuperscript{511} Id.
\textsuperscript{512} Id.
\textsuperscript{513} Id.
\textsuperscript{514} Clausen, supra note 45, at 37; see e.g.,UHCDA
who seek to override the directive from calling into question whether the patient had capacity when she executed the directive.

For example, Ms. Hargrave’s directive refused admission and treatment in a state hospital and administration of psychiatric medication.\(^{515}\) However, because Hargrave’s directive contained no physician attestation of her capacity at the time of execution, the hospital raised the issue that Hargrave’s directive may have bound her to her incompetent instructions.\(^{516}\) The hospital argued mental illness often causes a person to refuse medication and destroys the capacity required to follow a medication regime.\(^{517}\) The hospital posited there was less reason to presume competence of a person who executes a mental health directive than a person who executes a generic directive.\(^{518}\) People who execute mental health directives are presumably already mentally disordered.\(^{519}\) The hospital recommended a legislative requirement for psychiatric competency evaluation whenever a patient forms a mental health directive.\(^{520}\) A doctor’s attestation of Hargrave’s capacity would have prevented the hospital from arguing Hargrave’s instructions may have been illness induced refusals from an incapacitated patient.\(^{521}\)

2. Explain Rationale in Directive

A patient who explains the reasons she refuses or consents to identified interventions in her directive better ensures courts and clinicians follow the directive. For example, a patient whose directive refuses all psychotropic medication leaves treating physicians questioning whether her refusals were caused by an episode.\(^{522}\) However, a patient whose directive explains that she refuses lithium because she has suffered lithium toxicity and lithium administration could be dangerous has a far better chance of convincing her treating clinician to follow her directive.

Moreover, when a facility or physician seeks court authority to

\(^{516}\) Id. at 17-18.
\(^{517}\) Id. at 13.
\(^{518}\) Id.
\(^{519}\) Id. at 17-18; see also, Miller, supra note, at 738.
\(^{520}\) Brief of Appellant Respondent at 18 Hargrave v. Vermont, 340 F.3d 27 (2003), WL 32903163; see also, Miller, supra note, at 738-39, 745); Gallagher, supra note, at 778 (recommending lawyers assisting clients in executing mental health directives pay particular attention to assessment and attestation of capacity).
\(^{522}\) See supra Part I(A)(3).
administer treatment in contravention of a directive, the patient's reasoned treatment refusal may persuade the court to decline to authorize the treatment. A thorough explanation for the treatment refusal is evidence of the patient's capacity when she executed the directive and helps illustrate the treatment refusal was not illness induced.  

Similarly, a rationale articulated in a directive for consent to a particular treatment is excellent evidence of informed consent. Doctors are understandably wary of administering intrusive mental health treatments when they are unable to obtain contemporaneous informed consent from a patient with full capacity. Physicians administering treatment pursuant to a directive will feel more confident they are doing so with informed consent if the directive reveals the patient recognizes the specified risks, benefits, and alternatives.  

3. Identify Acceptable Interventions

When a patient uses a directive to refuse certain treatments, the patient should attempt to identify acceptable emergency interventions. Some patients will have already suffered episodes which have rendered them susceptible to emergency involuntary detention, screening, and treatment. The directive enables the patient to better control the emergency intervention utilized. The patient can use the directive to identify the appropriate intervention if an emergency makes intervention necessary.

For example, in her directive, Hargrave refused any and all psychiatric medication and hospitalization. She refused to consent to any emergency intervention and indicated no preference for any type of emergency treatment. The only intervention she authorized was to go outside for fresh air and exercise. Stating preferences for emergency intervention should it become necessary would have allowed Hargrave greater control over treatment administered in response to emergency situations.

4. Obtain Advance Buy-In from Physician

The patient can better ensure her physician follows her directive if she

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523 Id.
524 It is unlawful to administer treatment without informed consent. In order to provide alternatives to the treatment and must have full capacity.
525 See e.g., FLA. STAT. §765.101 (9) (2013).
527 Id.
528 Id.
not only explains her directive to her physician but creates the directive as part of a collaborative process with her physician.\(^{529}\) This shared decision-making allows the patient to explain the rationale behind her preferences and refusals of specified interventions.\(^{530}\) Current research indicates patients who are truly engaged in their care and participate in shared decision-making with their doctors are more satisfied with treatment and have better health outcomes.\(^{531}\)

**D. Guidance for Physicians**

1. Document Treatment Administered with Rationale

Mental health directives serve clinicians’ interests as much as they do patients’ interests.\(^{532}\) The directive is clear evidence of informed consent and prevents the administration of treatment which may have harmful side effects.\(^{533}\) Therefore, the directive minimizes physician liability for claims related to the unlawful administration of forced treatment.\(^{534}\) Healthcare professionals should carefully document all treatment administered, especially treatment administered in contravention of a directive. In instances in which the clinician is convinced she has authority to treat in contravention of a directive, she should clearly articulate in the patient records her rationale for abrogating the directive. The physician should also consult with the facility’s counsel to ensure the state override provision authorizes contravention of the directive. The rationale articulated in the patient record for treating in contravention of a directive should track the authority provided by the state statute override provision.

2. Seek Court Order before Directive Contravention

Even if the state statute does not expressly require a court order to treat in contravention of a directive, clinicians and facilities should seek such authority. Any time treatment is administered in contravention of a directive, facilities and clinicians are at risk for various claims related to

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\(^{530}\) Advising the Elderly Client, *supra* note 37, at §33:18.


\(^{532}\) Clausen, *supra* note 45, at 14-18.


\(^{534}\) Clausen, *supra* note, at 14-16; Coyle, *supra* note, at §24.
unlawfully administering forced treatment. A court order authorizing treatment in contravention of the directive deters such allegations and protects against liability for such claims.

3. Collaborate with Patients to Craft Crisis Intervention Plans

The mental health directive facilitates optimum care because it enables the patient to actively participate in shared decision-making. Studies reveal optimum patient satisfaction with care administered pursuant to an advance directive. Clearly articulated directives enable doctors to avoid the untenable position of having to respond to acute mental illness episodes without guidance from the patient as to what treatments have previously worked or proven harmful in the past. Not only will doctors be able to provide more effective care and prevent mental health crisis situations through collaborative use of a mental health directive, the ongoing dialogue will empower the patient, strengthen the doctor-patient relationship, and help prevent litigation from patients who believe their wishes have not been respected.

**CONCLUSION**

Many mental health directive statutes violate the ADA. They authorize directive contravention in emergencies (not further defined), by court order (without providing criteria for issuing such orders), and in the commitment context (without mandating an individualized dangerousness assessment at the time of directive abrogation). Authorizing directive abrogation in “emergencies,” without clarification, potentially authorizes directive abrogation for most acute mental illness episodes. If “emergencies” include situations endangering the patient’s mental health, most acute episodes constitute “emergencies.” This is because, if left

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535 Clausen, *supra* note 45, at 15.
536 Winick, *supra* note 29, at 81-82.
538 Richard A. Van Dorn et al., *Reducing Barriers to Completing Psychiatric Advance Directives*, 35 ADM. POL’Y MENT. HEALTH 440-48 (2008) (evidence indicating that health directives have strong clinical utility and are desired by patients).
539 Clausen, *supra* note 45, at 14-18.
540 Part II(B).
542 Part II(B)(1).
543 *Id.*
untreated, an acute mental illness episode will deteriorate the patient’s cognitive functions.\textsuperscript{544} However, many episodes do not threaten the health or safety of others.\textsuperscript{545} They do not justify the state in abrogating a mental health directive when the state cannot abrogate the directives of other people.\textsuperscript{546}

Similarly, authorizing mental health directive contravention for committed patients, but not other patients, violates the ADA.\textsuperscript{547} Even if a court found the patient dangerous at the time of initial commitment, many patients, after a period of hospitalization and treatment, no longer pose a direct threat to the health or safety of others.\textsuperscript{548} Therefore, the state is not exempt from the ADA under the direct threat exception.\textsuperscript{549} Finally, authorizing directive abrogation pursuant to court order, without further guidance, potentially violates the ADA.\textsuperscript{550} Such expansive override authority fails to ensure the direct threat exception is implicated each time a directive is abrogated.\textsuperscript{551} States should set forth criteria which must be met before a court can issue an order allowing directive abrogation.\textsuperscript{552} To comply with the ADA, such criteria must require a dangerousness assessment at the time of directive abrogation.\textsuperscript{553}

This Article’s model approach does not single out people with mental illness.\textsuperscript{554} For all forms of directives, it adopts the Uniform Act’s override provision and adds another override authority which allows directive contravention when following the directive poses a direct threat to the health or safety of others.\textsuperscript{555} Such emergencies may involve mental illness but may also involve unrelated issues, such a contagious tuberculosis patient who has formed a directive refusing quarantine and treatment.\textsuperscript{556} Directive abrogation in such instances falls under the direct threat exception and does not violate the ADA.\textsuperscript{557} Not only does the recommended approach comply with the ADA, it clarifies the relationship between mental health directive laws and commitment laws.\textsuperscript{558} States which adopt the model

\begin{itemize}
  \item \textsuperscript{544} \textit{Id.}
  \item \textsuperscript{545} \textit{Id.} 42 U.S.C. §12182(b)(3).
  \item \textsuperscript{546} \textit{Id.}
  \item \textsuperscript{547} \textit{Hargrave}, 340 F.3d at 36.
  \item \textsuperscript{548} \textit{Id.}
  \item \textsuperscript{549} \textit{Id.}
  \item \textsuperscript{550} \textit{See supra} Part II(B)(2).
  \item \textsuperscript{551} \textit{Id.}
  \item \textsuperscript{552} \textit{Id.}
  \item \textsuperscript{553} \textit{Hargrave}, 340 F.3d at 36.
  \item \textsuperscript{554} \textit{Id.} at 38.
  \item \textsuperscript{555} \textit{See supra} Part III(B).
  \item \textsuperscript{556} \textit{Id.}
  \item \textsuperscript{557} \textit{Id.} 42 U.S.C. §12182(b)(3).
  \item \textsuperscript{558} \textit{See supra} note 37 and accompanying text.
\end{itemize}
approach will provide clinicians much-needed guidance in responding to situations in which a patient’s directive refuses treatment necessary to prevent a risk of harm to the health and safety of others.\footnote{42 U.S.C. §12182(b)(3).}