Psychiatric Advance Directives and the Right to Be Presumed Competent

Maurice S. Fisher Jr.
I. CREATION OF THE RIGHT OF PSYCHIATRIC SELF-DETERMINATION AND THE PRESUMPTION OF COMPETENCY

In 1990, the Supreme Court of the United States recognized the right of a competent individual to control his or her own medical treatment when it noted that competent persons have a fundamental liberty interest in refusing unwanted medical treatment.\(^1\) In *Cruzan v. Director, Missouri Department of Health*, the Supreme Court found that where the "prior expressed wishes" of an incapacitated patient can be determined by clear and convincing evidence, those wishes should be honored.\(^2\) Implicit in this decision is the right of a patient to provide explicit instructions concerning his or her future medical care during a period of incapacity. The Supreme Court has since reaffirmed its implication in *Cruzan*, finding that "the right to refuse unwanted medical treatment [is] so rooted in our history, tradition, and practice as to require special protection under the Fourteenth Amendment."\(^3\)

With *Cruzan* laying the groundwork for the concept of an advance health care directive\(^4\), Congress passed the Federal Patient Self-Determination Act
(PSDA). The PSDA essentially requires health care providers to maintain written policies and procedures in order to provide information to adult patients regarding their right to accept or refuse medical treatment. Medical providers are also required to document whether or not a patient has executed an advance directive. Since Cruzan and the enactment of the PSDA, every state has created the right to execute advance health care directives in some form. As the use of advance directives became mainstream, health care professionals and patients began to find and demand more creative uses for them.

Less than one year after the Cruzan decision, New York recognized that a person's fundamental right to refuse medical treatment extends equally to patients who are mentally ill. Further, given that the concept of executing an advance directive is centered on the contemplation of future incapacity, mental health advocates began to make the logical argument that advance directives are particularly well suited for mentally ill patients. Because mentally ill patients often experience cyclical periods of competency and incompetency, advance directives would afford these patients the ability to better control the course of their treatment. Most advance health care directive statutes allow individuals to make decisions regarding future mental health care. However, a number of states have enacted separate statutes authorizing the execution of Psychiatric Advance Directives (hereinafter “PADs”).

All of the jurisdictions that have enacted the right to execute PADs utilize a similar framework. For instance, most state statutes afford a presumption of competency for purposes of executing a PAD. However, those of Louisiana and Indiana do not. The PAD statutes enacted in Louisiana and Indiana essentially take the position that one is incompetent until proven otherwise. Because of this stance, it is possible that those most likely to use PADs (i.e., those that suffer from some form of mental illness) could be

6. Id. at 1396a(w)(A)(i)(ii). This applies only to medical providers receiving Medicaid and Medicare payments. Id.
7. Id. at 1396a(w)(B).
8. See HEALTH-CARE DECISIONS ACT, supra note 4, at Prefatory Note.
12. Twenty-three states and the District of Columbia have enacted Psychiatric Advance Directive statutes. For a complete survey of the states that have enacted such statutes see infra notes 108-19.
deterred from taking full control over their mental health care decisions. This Note examines the legal framework through which PADs arose, and advocates that all future PAD statutes fully recognize a presumption of competency for the execution of a PAD. Section II identifies the constitutional and legal bases from which the concept of PADs sprang. Section III then explores the bases for a presumption of competency, both generally and in the context of PAD statutes, while considering relevant state interests. Finally, Section IV suggests that in the future, consumers in all states should have a fully recognized presumption of competency for purposes of executing a PAD.

II. PROTECTED LIBERTY INTERESTS

A. The Right to Refuse Medical Treatment is a Fundamental Liberty Interest under the Constitution

The right to refuse lifesaving medical treatment is assumed to be a fundamental liberty interest afforded to all competent persons by the Due Process Clause of the Fourteenth Amendment. Over the years, the Supreme Court has developed a framework to determine whether an interest rises to the level of a fundamental liberty interest protected by the Due Process Clause. The determining factor is whether the interest is so fundamental that it is embedded in the history and traditions of the United States. The Supreme Court, therefore, has never defined in absolute terms the "liberty" that the Due Process Clause protects. However, the Supreme Court has recognized that "liberty" must be broad enough to include, inter alia, "the right of the individual to . . . engage in any of the common occupations of life . . . and generally to enjoy those privileges long recognized . . . as essential to the orderly pursuit of happiness by free men."

By declining to recognize the right to have physician-assisted suicide, the Court expounded upon its inquiry regarding whether the right to refuse

13. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 279 (1990). In deciding under what circumstances an incompetent person may refuse lifesaving medical treatment, the Supreme Court in Cruzan assumed, without deciding, that a competent person has a constitutionally protected right to refuse lifesaving medical treatment. Id. The Supreme Court still has not explicitly recognized that there is a fundamental liberty interest in refusing lifesaving medical treatment. See e.g. Washington v. Glucksberg, 512 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793 (1997).


15. Id.


17. Id. (quoting Meyer v. Nebraska, 262 U.S. 390, 399 (1923)).
medical treatment is so fundamental as to require Fourteenth Amendment Due Process protection. In *Cruzan*, the Court found that implicit in the common law requirement of informed consent is the right of a medical patient to refuse lifesaving medical treatment.\(^{18}\) In *Washington v. Glucksberg*, the Court explained this right within the framework described above.\(^{19}\) The Court noted therein, in discussing the application of *Cruzan*, that a physician would effectively be guilty of the common law tort of battery if a physician forced unwanted medical treatment upon a patient.\(^{20}\) Therefore, it is well within the traditions of this country, both historically and legally,\(^{21}\) to recognize the right to refuse unwanted medical treatment as an interest that rises to the level of being so fundamental that the Constitution requires it to be protected.\(^{22}\) This right is not just simply inhered in one's personal autonomy.\(^{23}\)

**B. Limitations on the Right to Refuse Medical Treatment**

The right to refuse medical treatment as a fundamental right may be limited to instances where the medical treatment is for lifesaving purposes. For instance, the Supreme Court has differentiated between the withdrawal of lifesaving medical treatment and the administration of life-ending medical treatment.\(^{24}\) Further, under certain circumstances, the states have a right to limit the refusal of psychiatric medication (as opposed to lifesaving medication), but the Due Process Clause of the Fourteenth Amendment restricts a states ability to impose such a limitation.\(^{25}\) While mental health patients have a fundamental right to refuse antipsychotic medication, this

\(^{18}\) *Cruzan*, 497 U.S. at 279.

\(^{19}\) *See Glucksberg*, 521 U.S. at 725.

\(^{20}\) *Id.*

\(^{21}\) *Id.*

\(^{22}\) *Id.*

\(^{23}\) *Id.*

\(^{24}\) *See Vacco v. Quill*, 521 U.S. 793 (1997). Applying a rational basis analysis, the Court here noted that states have a compelling interest in preserving life, not intentionally hastening death. *Id.* at 808-09. Focusing on concepts of causation, the Court found that withdrawal of life saving medication results in a death that is caused by the underlying medical condition, whereas administering medical treatment to hasten death intervenes and deprives the underlying medical condition of actual causation. *See id.* at 800-02.

\(^{25}\) *See Washington v. Harper*, 494 U.S. 210 (1990) (holding that mentally ill state prisoners could be treated with antipsychotic medication against their will only if they were found to be severely disabled or dangerous); *Rivers v. Katz*, 67 N.Y.2d 485 (1986) (holding that involuntarily committed patients have a right to refuse treatment with antipsychotic medication, but that this right may subordinate itself to the state of New York's interest in providing care to its citizens who are unable to care for themselves and who present a danger to themselves or others).
right is not absolute. States have a compelling interest in administering such medication when patients present an imminent danger to themselves or others. Nonetheless, due process requires that a determination be made that the patient is incapable of making his or her own treatment decisions.

The Supreme Court has even held that an adult can, under certain circumstances (e.g., where a person who is in some way dangerous), be involuntarily committed for treatment of a mental health disorder or mental illness. The Court later elaborated, holding that persons may be involuntarily committed to mental health facilities if they are shown, by a minimum "clear and convincing evidence" standard, to be dangerous to either themselves or others. This further illustrates that the right to refuse medical treatment can be limited in certain contexts. Nonetheless, even cases that recognize these limitations—including the right to refuse antipsychotic medications—note that procedural due process requires a determination to be made that a given patient is incapable of making decisions concerning his or her medical treatment.

C. State Created Liberty Interests

In addition to the liberty interests found in the Due Process Clause, liberty interests may also be created through state law. The Federal Constitution independently protects these state created liberty interests.

In Wolff v. McDonnell, the Supreme Court found that prison inmates do not have a constitutionally protected liberty interest in receiving credit

26. Rivers, 67 N.Y.2d at 495. Note that this case deals with the rights of involuntarily committed patients.
27. Id. at 496. This is a valid exercise of a State's police power. Id.
28. Id. at 498.
29. See O'Connor v. Donaldson, 422 U.S. 563 (1975). Though the Court did not in this instance set forth the parameters or procedures for determining when a person can be committed, it did note that the Constitution does not allow the commitment of a non-dangerous person without more than the simple fact of mental illness. Id. at 575-76.
31. Rivers, 67 N.Y.2d at 498. This applies where the patient necessarily needs medication and is currently unable to care for himself.
33. Greenholtz, 442 U.S. at 7-9.
34. See Wolff, 418 U.S. at 556.
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However, the Court did find that the State of Nebraska had statutorily created this liberty interest. As such, the prison inmates were afforded the procedural protections of the Fourteenth Amendment to ensure that this state created right could not be arbitrarily countermanded. That is to say, the State of Nebraska may withhold an inmate’s liberty interest in receiving credits for good behavior if he or she has misbehaved, but this interest is protected by the Fourteenth Amendment.

Conversely, in *Meachum v. Fano*, the Supreme Court concluded that state prisoners had neither a constitutionally protected liberty interest, nor a state created liberty interest, in remaining free from being transferred from one prison to another of less than favorable conditions. Under these circumstances, Massachusetts law allowed for the transfer of prisoners from one prison facility to another, and these transfers were entirely discretionary under the law. Therefore, a liberty interest was not created to require that inmates be protected, under the procedural safeguards of the Fourteenth Amendment, from being arbitrarily transferred to other facilities.

Since *Wolff* and *Meachum*, the protocol for determining whether a state has created a constitutionally protected liberty interest has taken a circuitous course. In *Hewitt v. Helms*, the Supreme Court established a seemingly clear and reliable method for determining whether a liberty interest had been created by a state. The Court agreed that liberty interests could arise from two separate sources: either the Due Process Clause of the Fourteenth Amendment, or state law. Citing *Meachum*, the Court found that in order for a liberty interest to arise from state law, the state law’s procedural structure must be mandatory. The Court, focusing on the term “mandatory,” fashioned a test for recognizing state created liberty interests that centered on the language used in state statutes. Essentially, the test turned on whether the state law that allegedly created the liberty interest used language of an “unmistakably mandatory character.”

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35. *Id.* at 556-57.
36. *Id.*
37. *Id.*
39. *Id.* at 223-27.
40. *Id.* at 223.
41. *Id.* at 226.
43. *Id.* at 466.
44. *Id.* at 471-72.
45. *Id.* at 471.
"must," "shall," or "will" are compulsory and are therefore recognized as unmistakably mandatory.\(^4\)

\textit{Hewitt} examined whether a Pennsylvania statute created a liberty interest for prison inmates to remain in the general population of a penal facility.\(^4\) Following a jailhouse fight, the respondent was moved from the general population of the prison to administrative confinement.\(^4\) The respondent argued that jail officials violated his liberty interest in remaining in the general population.\(^4\) The Court determined that although the Fourteenth Amendment did not recognize such a liberty interest, Pennsylvania had created one statutorily.\(^5\) Pennsylvania law allowed for inmates to be moved into administrative confinement, but the law required certain procedures to be followed in order to effectuate such a move.\(^5\) By stating that prisoners "shall" be notified if they are being investigated for misbehavior, as well as stating that the investigation "shall" begin immediately, the Court found that the Pennsylvania law was sufficiently mandatory in nature and therefore created a protected liberty interest.\(^5\)

Fifteen years after \textit{Hewitt}, the Court curtailed its "mandatory language" test somewhat in \textit{Sandin v. Conner}.\(^5\) Due to the great emphasis being placed on the phraseology of the state statutes, the Court became concerned that courts were concluding too readily that states had created liberty interests.\(^5\) As a result, the Court found that while states may create protected liberty interests, the circumstances under which such interests are created are generally limited to freedom from restraint.\(^5\) In effect, the Court held that the test for determining whether a state has created a protected liberty interest is found in the cases of \textit{Wolff} and \textit{Meachum}.\(^5\) Under \textit{Sandin},

\begin{itemize}
  \item [46.] \textit{Id.}
  \item [47.] \textit{Id. at 466.}
  \item [48.] \textit{Hewitt}, 459 U.S. at 462-64.
  \item [49.] \textit{Id. at 462.}
  \item [50.] \textit{Id. at 467.}
  \item [51.] \textit{Id. at 471 n.6.}
  \item [52.] \textit{Id. at 477.} It is important to note that while the Court found Pennsylvania had created a liberty interest, it ultimately determined that the procedures sufficiently protected that interest.
  \item [54.] \textit{Id.} As a result of the mandatory language test, the Court found that prisoners were combing state statutes that used the magic words of "shall," "will," or "must" and that lower courts were finding too many state created liberty interests where they really did not exist, based purely on the language used and not on the substance. \textit{Id.}
  \item [55.] \textit{Id. at 484.}
  \item [56.] \textit{See Christie v. Barrington}, No. 94-1653, 1995 WL 417615, at *3 (7th Cir. Jul. 13, 1995). In determining whether a state has created a liberty interest that must be given the procedural protections of the Fourteenth Amendment, the Supreme Court in \textit{Sandin}
it is no longer sufficient that state law contain mandatory language, but such language may still be regarded as a prerequisite to finding a state created liberty interest. As a result, it is important to note that many of the Court's post-Hewitt and pre-Sandin decisions have remained undisturbed.

Before the Supreme Court officially assumed that all competent persons have a fundamental liberty interest in refusing medical treatment, the Court dealt with a line of cases involving the right of mentally ill patients to refuse antipsychotic medication. The first case was Mills v. Rogers. The issue in Mills was whether involuntarily committed mental patients possess a constitutional right to refuse the administration of antipsychotic medication. Several mental patients brought the case as a class action against the Commonwealth of Massachusetts. By the time the case was eligible for consideration, however, the Supreme Judicial Court of Massachusetts had issued a ruling that the Court determined would affect the outcome of the Mills case, thereby causing the Court to remand the Mills case. In issuing the remand order, the Court noted that while it would not decide whether the involuntarily committed mental patients had a protected liberty interest under the Fourteenth Amendment, Massachusetts' law may recognize greater liberty interests than those found in the Constitution. Therefore, a remand was ordered so that the extent of Massachusetts' newly created liberty interest could be determined.

The relevant decision was In the Matter of Guardianship of Roe, decided by the Supreme Judicial Court of Massachusetts. Unlike the respondents in Mills, Roe was not institutionalized, but the issue did involve Roe's right to refuse antipsychotic drugs. The Supreme Judicial Court of Massachusetts held that the common law of Massachusetts, as well as the Constitution, created a protected liberty interest in refusing the administration of antipsychotic drugs. The court noted that Massachusetts mandated that a

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| 57 | Id. |
| 58 | See supra note 13 and accompanying text. |
| 60 | Id. at 298. |
| 61 | Id. at 294. |
| 62 | Id. at 300-03. |
| 63 | Id. at 300. |
| 64 | Id. at 303. |
| 66 | Id. at 42. |
person is presumed competent, unless deemed otherwise. Furthermore, even when a person has been adjudged incompetent, his right to refuse antipsychotic medication stands. Incompetent persons are entitled to have a judicial determination of substituted judgment whereby the incompetent person's subjective preferences are determined. The decision was, however, limited to patients who were not institutionalized.

When Rogers v. Mills was remanded, the task of the First Circuit Court of Appeals was to determine Rogers's rights in light of Roe. The First Circuit reaffirmed that the Fourteenth Amendment's Due Process Clause affords procedural protections to state created liberty interests. However, in order to determine fully which substantive rights are afforded to involuntarily committed mental patients under state law, the First Circuit certified a number of questions to the Supreme Judicial Court of Massachusetts. The Supreme Judicial Court recognized several factors that effectively create "objective expectations" through which involuntarily committed mental patients may be given antipsychotic medications against their will. Most important to this analysis is the fact that mental patients have an objective expectation that their involuntary commitment does not rise to the level of a determination of their incompetency to make treatment decisions. Pursuant to this objective expectation, the Supreme Judicial Court of Massachusetts determined that the state had created procedural expectations that an incompetency determination must be made by a judge at law, and no one else. Further, these patients have an objective expectation that, if declared incompetent, they are entitled to a substituted judgment treatment decision, as well as a state created procedural expectation that only a judge can make this decision.

67. Id. at 55.
68. Id. at 51-52.
69. Id. at 52.
70. Id. at 61-62.
71. Rogers v. Okin, 738 F.2d 1, 3 (1st Cir. 1984).
72. Id. at 5.
73. Id. This note is only concerned with the responses given to three of the nine questions.
74. Id. at 6.
75. Id.
76. Id. at 7.
77. Rogers, 738 F.2d at 6.
78. Id. at 7.
III. THE RIGHT TO BE PRESUMED COMPETENT

A. Common Law and Statutory Rights Presuming Competency

As a preliminary matter, the distinction between the terms "competency" and "capacity" must be fleshed out. The concept of "competency" is one developed by and belonging solely to the study of law, and must be demarcated from the notion of "capacity." "Capacity" is a term used by mental health professionals to assess a patient’s level of competence. That is to say, while courts are the arbiters of whether one is competent, it is the job of the clinicians to inform the court’s decision by establishing one’s capacity. A person may have many levels of capacity, but one either is, or is not, legally competent. The law presumes competency, and the burden of proving incapacity is on the party challenging one’s competence. Nonetheless, the terms are often used interchangeably.

The law requires that individuals be competent to enjoy many legal rights. For example, one must be competent to execute wills, engage in sexual intercourse, enter into contracts, make health care decisions, and to stand trial. In the context of criminal law, the Supreme Court has held that a state statute creating a presumption that defendants are competent to stand trial is not a violation of the Due Process Clause of the Fourteenth Amendment. Under the Constitution, it is acceptable that the defendant have the burden of proving incompetency. With regard to entering into a contract or giving a gift, all persons are presumed to be competent, and the burden is on the party that wishes to attack another party’s competency to prove incompetency. At the same time that the law presumes competency, it does not presume incompetency. Further, the presumption of competency is not rebutted simply because a person may have lost competence at some point. The presumption remains intact because a period of incompetence does not necessitate the conclusion that a person will remain incompetent. Even

80. Id. at 348-49.
81. Id. at 349.
82. Id.
85. Id. at 452-53.
further, the presumption remains intact even when a party is proven to have been involuntarily committed some years prior to exercising a legal right.  

All competent adults should have the ability to make decisions concerning their future mental health care. Stated differently, one must be competent to execute a valid Psychiatric Advance Directive. As the case law has developed, it has become clear that one’s competence to make such decisions must be presumed. Not even in the face of psychiatric illness or psychiatric commitment can this presumption be fully rebutted. Short of a court order to the contrary, one’s ability to make his or her own health care decisions will remain intact. For instance, the Commonwealth of Massachusetts affords one the presumption of competency to refuse antipsychotic medication unless a court orders him or her incompetent to make the decision to refuse. 

The presumption of competency is so strong that many states codify it in particular contexts. For instance, Alaska provides that even when a person has become incapacitated to such an extent that a guardian has been appointed for him or her, that person nevertheless retains all legal rights that have not been stripped away by a court order; moreover, that person is otherwise presumed competent. Under California law, a person’s presumption of competency should remain unaffected, and he or she should not be presumed incompetent solely due to evaluation or treatment for a mental disorder, regardless of whether that treatment or evaluation was voluntary or involuntary. Louisiana, in its enumeration of the rights guaranteed to the mentally ill, provides that patients in mental health

90. Sobberri v. Cookston, 438 So.2d 688 (La. Ct. App. 1983) (applying a state statute mandating that there is to be no presumption of incompetence regardless of whether a person has been voluntarily or involuntarily committed to a mental health institution).


93. Gallagher, supra note 11, at 766.

94. See id. “The courts have made clear that neither the fact of psychiatric illness itself, nor the fact of commitment for psychiatric treatment, is tantamount to a determination of incompetence to make treatment decisions.” Id.

95. See id. It would take more than a court order finding a patient’s incapacity and the appointment of a guardian to overcome the presumption of competency such that a person may be deprived of their ability to make their own health care decision. See id.


facilities are not presumed incompetent. Furthermore, that right remains even when a patient is involuntarily committed to the mental health facility. Only a court can determine that a person is incompetent. Illinois has a similar statute. Texas further provides that the presumption of competency is a basic right afforded to persons with mental retardation.

B. PAD Statutes and the Presumption of Competency

Spurred by Congress’ enactment of the Patient Self-Determination Act, each state has enacted a statute allowing for the execution of an advance directive. Many states have adopted The Uniform Health-Care Decisions Act, which affords the ability to make decisions concerning the treatment of future mental health issues by allowing for mental health directives to be incorporated into general advance medical directives. The statute provides that “an individual is presumed to have capacity to make a health-care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate.” Other states, however, have enacted separate statutes allowing for the execution of a specific Psychiatric Advance Directive.

Twenty-three states and the District of Columbia have enacted separate statutes authorizing the execution of PADs. These states can be divided into five categories based on the level of competency required for a patient to execute a PAD. Three states create a presumption of competency.

100. Id.
101. Id.
102. 405 ILL. COMP. STAT. 5/2-101 (2007).
103. TEX. HEALTH & SAFETY CODE ANN. § 592.021 (Vernon 2003).
105. HEALTH-CARE DECISIONS ACT, supra note 4, at Prefatory Note.
106. Id.
107. Id. § 11(b).
108. See e.g. statutes cited infra notes 110-19. This number was gleaned from the sum of the states listed in the five categories based on the level of competency required for a patient to execute a PAD.
109. See Debra S. Srebnik & Scott Y. Kim, Competency for Creation, Use, and Revocation of Psychiatric Advance Directives, 35 J. AM. ACAD. PSYCHIATRY L. 501, 503 (2006). The individual state statutes falling within the categories designated by Srebnik have been supplemented and updated through the author’s own independent survey of the current posture of PAD statutes in all fifty states and the District of Columbia. See statutes cited infra notes 110-19.
For example, Hawaii’s PAD statute provides that “a principal is presumed to have capacity to make mental health care decisions and to execute or revoke an advance mental health care directive . . . .”\textsuperscript{111} Seven other states require that witnesses to the execution of a PAD attest that the patient is of “sound mind;”\textsuperscript{112} four states require that witnesses attest that the patient is “competent;”\textsuperscript{113} eight states require that the patient either have “capacity” or be “not incapacitated.”\textsuperscript{114} Lastly, two states require that a patient either submit to a “mental status exam;”\textsuperscript{115} or have a psychiatrist attest to his or her capacity to execute a PAD.\textsuperscript{116} There is cause for concern with regard to the position taken by these latter two states.

1. \textit{Louisiana’s PAD Statute}

Louisiana’s PAD statute phrases its competency requirements for execution in negative terms. The Louisiana Advance Directives for Mental Health Treatment statute provides that “an adult who is not incapable” may execute a PAD.\textsuperscript{117} This provision, taken alone, is similar to provisions found in PAD statutes from other states.\textsuperscript{118} However, the Louisiana statute goes

\begin{itemize}
\item \textsuperscript{110} HAW. REV. STAT. §§ 327F-1 to 327F-16 (1993); KY. REV. STAT. ANN. §§ 202A.420 to 202A.991 (LexisNexis 2007); WASH. REV. CODE §§ 71.32.010 to 71.32.901 (2008).
\item \textsuperscript{111} HAW. REV. STAT. § 327G-7 (1993).
\item \textsuperscript{112} ALASKA STAT. § 13.52.300 (2006); D.C. CODE § 7-1231.06 (2001); 755 ILL. COMP. STAT. 43/1 to 43/75 (2006); N.J. STAT. ANN. § 26:2H-105 (West 2007); N.C. GEN. STAT. §§ 122C-71 to 122C-77 (2001); OR. REV. STAT. §§ 127.700 to 127.735 and 127.995 (2005); S.D. CODIFIED LAWS §§ 27A-16-1 to 27A-16-18 (2004).
\item \textsuperscript{113} IDAHO CODE ANN. §§ 66-601 to 66-613 (2002); ME. REV. STAT. ANN. tit. 18-A, § 5-802(i) (Supp. 2007); ME. REV. STAT. ANN. tit. 34-B, §§ 3831, 3862 (2004); MD. CODE ANN., HEALTH-GEN. §§ 5-602.1 (West Supp. 2005); MINN. STAT. 253B.03 (2006).
\item \textsuperscript{116} IND. CODE § 16-36-1.7-2 (2004).
\item \textsuperscript{117} LA. REV. STAT. ANN. § 28:222(a) (2001 & Supp. 2008).
further to require that the PAD be "accompanied by a written mental status examination performed by a physician or psychologist attesting to the principal's ability to make reasoned decisions concerning his mental health treatment." The statute also outlines the specific criteria by which the attesting physician or psychologist should base his or her determination. The criteria to be considered are:

1. whether the principal demonstrates an awareness of the nature of his illness and situation;
2. whether the principal demonstrates an understanding of treatment and the risks, benefits, and alternatives; and
3. whether the principal communicates a clear choice regarding treatment that is a reasoned one, even though it may not be in the person's best interest.

These outlined requirements are remarkably similar to those that must be met to show adequate testamentary capacity under Louisiana law. As is the case in most states, a testator in Louisiana has the requisite capacity to execute a will if it is found that the testator could have fully understood the nature of the testamentary act and appreciate its effects. Furthermore, it has recently been reaffirmed that testamentary capacity is presumed in Louisiana. Oddly, the Louisiana PAD statute does not afford a living person the same presumption of competency as it does the deceased. In effect, the Louisiana PAD statute requires a person who wishes to execute a PAD to prove his or her competence by requiring a physician to attest to it. This seems to countervail other more deeply rooted principles of Louisiana law.

Notably, not only does Louisiana presume the competence of decedent testators, the state has also statutorily created the strong presumption that periods of commitment to a mental health facility cannot override the general presumption of competency. Further, Louisiana has mandated

120. Id.
122. See id.
124. Id.
125. LA. REV. STAT. ANN. § 28:171(B) (2001 & Supp. 2008). "No patient in a treatment facility shall be presumed incompetent, nor shall such person be held incompetent except as determined by a court of competent jurisdiction." Id. (2001 & Supp. 2008); see also Sobberri v. Cookston, 438 So.2d 688, 690 (La. Ct. App. 1983) (finding that a person's capacity to enter into contracts is unaffected by a commitment to a treatment facility for mental illness since such a commitment does not create a presumption of incompetency under the above referenced statute).
that a person can only be found incompetent through a judicial determination.\textsuperscript{126}

2. Indiana's PAD Statute

Concerning the execution of a PAD, Indiana's statute is very similar to Louisiana's. Indiana's statute provides that any person with capacity may execute a PAD,\textsuperscript{127} but the statute also requires "the psychiatrist treating the individual" to attest to:

(A) the appropriateness of the individual's preferences stated in the psychiatric advance directive; and
(B) the capacity of the individual entering into the psychiatric advance directive.\textsuperscript{128}

The plain language of this statute unabashedly presupposes that those who wish to execute a PAD are currently psychiatric patients. This is evident from the requirement that a treating psychiatrist attest to the ability of the person executing the PAD.\textsuperscript{129} Even Louisiana's statute is more broadly drawn.\textsuperscript{130}

Like Louisiana law and that of nearly every state, Indiana's case law recognizes that all persons are presumed to have the capacity to execute a last will and testament.\textsuperscript{131} To do so, a person need only have the capacity to understand the nature and the effects of executing a will.\textsuperscript{132} Indiana has statutorily extended this presumption that individuals have the capacity to execute a will by incorporating the presumption of capacity into the rights of patients being treated for mental illness.\textsuperscript{133} In other words, unless a person has been adjudicated incompetent, he or she is entitled to enjoy all of the rights naturally afforded to all persons under the law.\textsuperscript{134}

\textsuperscript{127} IND. CODE § 16-36-1.7-2 (a) (2004).
\textsuperscript{128} IND. CODE § 16-36-1.7-2 (b)(7)(A) and (B)(2004).
\textsuperscript{129} It is probably fair to say that one does not have a "treating physician" if they are not already a current patient.
\textsuperscript{130} LA. REV. STAT. ANN. § 28:224 (2001 and Supp. 2008). The Louisiana statute arguably makes no presupposition that persons seeking to execute a PAD are currently being treated by a psychiatrist since the statute requires all persons executing a PAD to submit to a mental status exam.
\textsuperscript{132} Id.
\textsuperscript{133} See IND. CODE § 12-27-2-3(a) (2004).
\textsuperscript{134} Id. "A patient is entitled to exercise the patient's constitutional, statutory, and civil rights except for those rights that have been denied or limited by an adjudication or finding of mental incompetency in a guardianship or other civil proceeding." Id.
Historically, both Louisiana and Indiana law have recognized that all persons are presumed competent. Consequently, the citizens of these two states have a justifiable expectation that should their competency be called into question, the courts will make that determination. Arguably, this interest rises to the level of being a liberty interest worthy of constitutional protection under the Due Process Clause of the Fourteenth Amendment. If so, the explicit language of the Louisiana and Indiana PAD statutes abrogates a protected liberty interest by not providing due process of law. By mandating a physician to administer a mental status examination, or by requiring that a treating psychiatrist attest to the competency of a patient who desires to execute a PAD, Louisiana and Indiana allow physicians to do something they themselves are ironically incompetent to do: determine competency.

Competency is a legal standard, and the law of both states requires a judge to make this determination. Nonetheless, this right must be balanced against the interests of the state.

C. State Interests Concerning the Presumption of Competency with Respect to PAD Execution

Those who advocate the use of PADs argue that the presumption of competency should not be abandoned simply because a person is mentally ill. These advocates note that many circumstances, including myriad physical illnesses, may affect the cognitive capacity of an individual in

135. Louisiana law states that not even patients in treatment facilities can be presumed incompetent and that it is the sole province of the courts to determine whether such a patient is incompetent. LA. REV. STAT. ANN. § 28:171(B) (2001). Indiana law also essentially provides a presumption of competency to patients being treated for a mental illness by stating that such patients have a right "to exercise [their] constitutional, statutory, and civil rights" to the extent that the ability to exercise those rights has not been taken away from them by an "adjudication or finding of mental incompetency." IND. CODE § 12-27-2-3(a) (2004).

136. See supra notes 79-83. Psychiatrists, as medical doctors, are only competent to assess a patient's capacity, not a patient's competency. Competency is a legal standard that remains within the sole province of the courts. See id.

137. See Berg, Applebaum & Grisso, supra note 79.

138. See e.g., Washington v. Harper, 494 U.S. 223 (1990) (holding that where a mentally ill prisoner is a threat to his own safety and the safety of others, treatment against the prisoner's will is not a violation of the prisoner's substantive due process rights).

139. Debra Srebnik & Lisa Brodoff, Implementing Psychiatric Advance Directives: Service Provider Issues and Answers, 30 J. BEHAV. HEALTH SERV. & RES. 253 (2003). The presumption of competency is afforded equally to persons seeking to execute general health care directives, and one's competency should not be questioned simply because they seek to execute a PAD. See id. at 257.
similar ways as mental illness, but the competency of the physically ill is not questioned.\textsuperscript{140}

One of the major concerns voiced by some mental health care providers is that mentally ill persons may not be competent to execute a PAD.\textsuperscript{141} There is a concern that the practical effect of presuming competency is to make it nearly impossible to rebut this presumption. That is, it may be difficult to later corroborate the patient’s level of competency at the time the PAD was executed.\textsuperscript{142} The inference here is that mental health care providers may not be willing to follow a patient’s PAD during a mental health crisis if they do not have faith that the patient was actually competent when it was executed.\textsuperscript{143} Consequently, there is strong support for requiring specific competency requirements for patients wishing to execute PADS.

Nonetheless, there is some agreement over what the definition of competency should entail. The level of competence required to execute a PAD “appear[s] to require at least the ability to understand and appreciate the risks and benefits of various therapeutic alternatives as well as the ability to engage in the process of rational deliberation.”\textsuperscript{144} In other words, a patient must be able to fully comprehend that he or she is making present choices regarding preferred psychiatric care during future times of incapacity.\textsuperscript{145} However, this is likely a manifestation of the confusion over the difference between capacity and competency.\textsuperscript{146}

In one of the earliest arguments advocating for the use of binding advance directives in the context of mental illness, competency was presupposed.\textsuperscript{147} Where a patient demonstrates intermittent levels of lucidity, based on the cyclical nature of his or her mental illness, advocates assert that statements

\begin{itemize}
\item \textsuperscript{140} \textit{Id.} at 257. For example, multiple sclerosis, AIDS, and dementia all alter one’s cognitive capacity.
\item \textsuperscript{141} \textit{Id.} at 256-57.
\item \textsuperscript{142} Srebnik & La Fond, \textit{supra} note 92, at 921.
\item \textsuperscript{143} See Srebnik & Brodoff, \textit{supra} note 139, at 257.
\item \textsuperscript{144} Gallagher, \textit{supra} note 11, at 777. Furthermore, a patient must be able to understand the consequences of executing a PAD on their future treatment during a time of incapacity. \textit{Id.}
\item \textsuperscript{145} Patricia Backlar, \textit{Ethics in Community Mental Health Care: Anticipatory Planning for Psychiatric Treatment is Not Quite the Same as Planning for End-of-Life Care}, 33 COMMUNITY MENTAL HEALTH J. 261, 265 (1997).
\item \textsuperscript{146} See \textit{supra} Section III. A.
\item \textsuperscript{147} Morton E. Winston & Sally M. Winston, \textit{Case Studies: Can a Subject Consent to a “Ulysses Contract”? Commentary}, THE HASTINGS CENTER REPORT, Aug. 1982, at 26, 27. This article refers to binding advance directives known as “Ulysses Contracts,” harkening back to the story of Ulysses and his battle of temptation caused by the song of the Sirens.
\end{itemize}
made during these periods of lucidity best express a patient’s wishes. The fact that a patient suffers from a mental illness should bear no influence on his or her level of competency during times of lucidity. The fact that a person suffering from mental illness should be considered legally competent during periods of lucidity is bolstered by a case study which was performed in 1982. There, the patient consented to experimental treatment during a period of lucidity, but later refused the experimental treatment once he came off of his antipsychotic medications, thereby causing his mental stability to deteriorate and effectively render him incompetent. Once the patient was given his medications and he regained his lucidity, the patient was disappointed to learn that the experimental treatment had not been administered, and he manifested a strong desire to follow through with the experimental treatment again.

Mental health professionals tend to determine a patient’s level of competency by focusing on the severity of a patient’s mental illness. However, it has been shown that one’s cognitive ability may be a better indicator. The competency level of psychiatric patients has been demonstrated to be statistically indistinguishable from the competency level of normal medical patients. Across the board, mentally ill patients demonstrated a similar ability to both comprehend information required to obtain informed consent and make rational choices regarding their medical treatment. Further, even those patients exhibiting the most chronic levels of mental illness were able to comprehend information and make rational decisions.

By most measures of incompetency, there is no doubt that many mentally ill and chronically mentally ill persons are competent. Mentally ill persons are not per se incompetent, in the same way that mentally healthy persons are not per se competent. Just as certain physical illnesses may render a mentally healthy person incompetent, the competency level of mentally healthy persons can also be influenced by stress, emotions,

148. Id.
149. Id.
150. Id.
151. Id. at 16.
153. Id. at 2.
154. Id.
155. Id. at 3.
156. Elyn R. Saks & Dilip V. Jeste, Capacity to Consent to or Refuse Treatment and/or Research: Theoretical Considerations, 24 BEHAV. SCI. & L. 411, 426 (2006).
157. Id.
158. Srebnik & Brodoff, supra note 139.
personal fantasies, and the overvaluation of memories or irrational decision-making.  

Another study that examined the ability of mentally ill patients to comprehend informed consent disclosures concluded that schizophrenic patients are more likely to demonstrate lower levels of understanding of treatment disclosures than are normal medically ill patients. This study tested mentally ill patients that were hospitalized in an acute psychiatric care unit. Therefore, this study likely makes no statement as to the competency of mentally ill patients during periods of lucidity. Notably, the authors of the study stated that the results of this study should not be used to make conclusions concerning the relative legal competencies of mentally ill and medically ill patients. Furthermore, there is ample evidence to support the proposition that a mentally ill patient's level of competency to consent to treatment shifts as his or her condition improves through treatment.

IV. CONCLUSION

It is fairly well settled that all competent persons have the right to refuse unwanted medical treatment, even if such treatment would be lifesaving. As a result, individuals have the right to execute instructions memorializing their present intentions concerning future medical treatment during times of incapacity. Every jurisdiction in this country has established laws allowing these types of decisions in the form of general advance medical directives. Roughly half of all U.S. jurisdictions have enacted separate statutes, in the form of PADs, that allow for the execution of similar directives concerning future psychiatric treatment during times of incompetency. The law generally presumes that all persons are competent, regardless of whether or not they have had prior periods of incompetency or are currently committed to mental health institutions. The presumption of competency is firmly rooted in the laws of our states, and many states have enacted statutes memorializing this right.

Moreover, only courts of law may adjudge one as incompetent. The right to be presumed competent is so prevalent in all areas of the law that it

159. Saks & Jeste, supra note 156, at 426.
161. Id. at 379.
162. Id. at 387.
arguably rises to the level of a liberty interest created by both the statutory and common law of the states. The procedural requirement entrusting judges as arbiters of the determination of incompetency provides sufficient protection under the Due Process Clause. Most states that have enacted PAD statutes recognize the right to be presumed competent to execute a PAD, either explicitly or through lenient execution requirements. The PAD statutes in Indiana and Louisiana, however, differ in that they respectively require either a mental status examination, or the attestation of a treating psychiatrist to ensure that a person or patient is competent to execute a PAD. These requirements violate the expectation of persons in those states to be presumed competent, and remove the judiciary's right to determine competency. As such, the Louisiana and Indiana statutes violate the liberty interests created by the tradition of the common law in those states, as well as other Louisiana and Indiana statutes specifically affording all persons the right to be presumed competent. Moving forward, all states that have not yet enacted PAD statutes should seek to emulate those states that have provided for a presumption of competence directly in their PAD statutes. Doing so will ensure that all individuals, regardless of their propensity for mental illness, are afforded the fundamental liberty interest of making decisions regarding future health care treatment.