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Erratum
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THE NEXUM: A MODEST PROPOSAL FOR SELF-GUARDIANSHIP BY CONTRACT: A SYSTEM OF ADVANCE DIRECTIVES AND SURROGATE COMMITTEES-AT-LARGE FOR THE INTERMITTENTLY MENTALLY ILL

Paul F. Stavis

INTRODUCTION

The term commonly used to describe government provision and funding for the care of persons with serious mental illness is the "mental health system." Unfortunately, forty years of deinstitutionalization and many years of court-imposed crypto-criminal procedures on individuals with mental illness has deconstructed the system and created an anti-therapeutic, adversarial environment. The mental health system needs to be restructured in a way that is consistent with modern scientific knowledge about mental illness, with national policies that promote patient autonomy and alternatives to current judicial dispute resolution. This paper proposes a new system of informed consent for persons who require assistance in managing their mental illness. It creates a form of self-guardianship by an advance directive contract. This new alternative system, utilizing a contractual approach, is called the "Nexum."
Among the untoward consequences of current mental health laws and policies is the increase in both the number of mentally ill appearing in the nation's prisons and jails, and among the homeless population. These individuals also experience the loss of the ability to live freely and productively in their community. Reforms of the last forty years, including de-institutionalization, court-mandated due process, and a substantial increase in available legal advocacy, were meant to serve patient interests, but in reality, the results act against both the privacy of the patient and the public interests of society by pitting civil rights concerns against necessary therapeutic intervention.

One of the most important issues at the center of this contemporary controversy over mental illness is that of compelled treatment for patients lacking the fundamental awareness of their mental illness or their need and suitability for treatment. Diametrically opposed forces have battled over the appropriateness and conditions under which treatment may be compelled for persons with mental illness, a fight in which courts have become a major forum. Following the tradition of court activism of the 1950's, thirty years of mental health litigation has produced a myriad of judicially mandated due process principles. This court activism has changed public mental health treatment from primarily a "medical model" into one that mirrors a "legal model" of care and treatment. Indeed, even beyond a mere legal model, the model of due process has been largely a crypto-criminal procedure. Because of the intensified adversarial roles and the generally overburdened court system, large amounts of time, resources, and energy have been devoted to legal activities rather than medical ameliorations. This obviously does not alleviate mental illness and is not conducive to a therapeutic alliance between the patient, the physician, and the health care treatment system. Thus, in the interests of what is understood as the protection of civil rights, the courts have unwittingly created substantial barriers to treatment that often diminish patient autonomy and exacerbate the condition of their illness.

Ironically, these developments have proved acceptable to governmental mental health bureaucracies due to intense efforts to cut treat-

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ment costs of the most seriously mentally ill. While persons with severe mental illness often require more intensive supervision and services due to their general lack of insight, this treatment is expensive to provide. Moreover, the patient with severe mental illness is often highly resistant to psychiatric treatment. Finally, there are substantial legal liabilities for treatment providers which represent a perverse disincentive to treatment.

This article drafts a blueprint for a systemic approach to treating serious mental illness based on science, sound social policy, and modern methods of dispute resolution. This system uses traditional contractual principles as the foundation for permitting the patient and physician to jointly address circumstances of decisional impairment caused by mental illness. The patient will be given an opportunity to participate in predefining both the terms of his or her decision-making incapacity and the professionally acceptable treatments that are mutually believed to be in his or her best interests. The treatment system will reap the benefits of being able to render treatment under a medical model, i.e., without having to resort to courts of law for authorization or validation of clinical judgments where a patient is competent to give informed consent on expeditious and appropriate treatment. In the event that disputes arise over the Nexum agreement, legal issues, changing conditions, or a patient's best interests, this system will utilize alternative dispute resolution methods to quickly resolve the issues while protecting all legal rights under current federal and state laws.

Designing a new system specifically aimed at maximizing patient autonomy, effective treatment, and reduced costs, while relieving an overburdened court system, should produce distinct benefits for all concerned. The primary goals of this system would be to enhance the autonomy and dignity of the patient, while largely eliminating the role of the judiciary which has, in many instances, inappropriately insinuated itself into the therapeutic relationship between the patient and his doctor.

In this system, the patient, in consultation with his physician, will choose among legally and professionally acceptable options on three issues. First, under contractual principles, the patient will, with medical and legal advice, define the terms of his or her decision-making incompetence within legally acceptable principles, based upon an authorizing statute and professionally acceptable medical standards. Second, pursuant to authorization by statute and the express terms of
the Nexum contract, the patient will give prospectively informed consent for defined treatments while granting implied consent for other treatments under a physician’s discretion, that will address any unanticipated circumstances which the patient’s mental illness might produce at the time that treatment is rendered.

Third, and the most unique component of the Nexum system which takes it beyond other advance directive statutes for persons with mental illness, is the incorporation of a statutorily authorized alternative dispute resolution program to resolve disagreements, to make interpretations of contractual terms, to resolve disputes, or to recognize changes in the circumstances or other unforeseen problems surrounding a patient’s mental health treatment. Under this dispute resolution program appropriate treatment can be legally authorized. Modeled after the Surrogate Decision Making Committee (SDMC) system in New York State, an administrative adjudicative panel composed of a physician or a nurse, a lawyer, and two patient advocates or family members familiar with the issues and concerns of persons who have serious mental illness may decide issues of decision-making competency and appropriate medical treatment for a patient. SDMC has already proven effective in protecting patient rights, garnering the trust of patients, providers, the bureaucracy and the judiciary, and also successful in minimizing delay, costs, and appeals to courts of law. Although SDMC does not currently include advance directive disputes in its jurisdiction, the system makes effective and relatively error-free determinations of patient decision-making competency and the patient’s best interests in matters of major medical care that are essentially the same as might arise under a Nexum.

I. HISTORICAL AND PHILOSOPHICAL BACKGROUND

During the last two millennia of western thought, law and custom assigned to governments two primary functions covering subjects with mental illness in need of care and treatment. Under its police power, a

3. See N.Y. MENTAL HYG. LAW, ARTICLE 80.
4. See Clarence J. Sundram and Paul F. Stavis, New York’s Surrogate Decision Making Law – Ten Years Later, 22 INT’L J.L. & PSYCHIATRY 107 (1999); Originally created in New York State, this approach has been replicated in one other state. See TEXAS HEALTH & SAFETY CODE ANN. TITLE 7, ch. 59 (West 1999).
government must maintain the social order against any potential or actual dangers by a person due to mental disorder. Secondly, under its *parens patriae* power, the government may attempt to restore the person’s decision-making ability by ameliorating the mental illness.\(^5\)

The right of autonomy over body and mind under law is fundamentally justified by a person’s mental “competence” to exercise rights and privileges. Here, it is discussed as a legal concept.\(^6\) Until recently, the definition of mental illness has been a concept constructed from the culture and science of the era, though in previous ages it was thought to be caused by a possession by demons, reversion to an animalistic level of behavior, or a punishment from God. Although Hippocrates was one of the first to postulate that mental illness had biological or organic causes, many cultures believed mental illness originated from spiritual and mystical causes. Hippocrates thought that a place of asylum, where individuals would have a minimum level of mental stress and purity of air and water, would be appropriate treatment. Yet, the Greeks and most other cultures recognized that to exercise rights, one must not endanger oneself or others. If the purposes of society were self-preservation for the whole and for the individuals of society, then the survival of its members would be tenuous indeed if it

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5. *“Parens patriae” literally means “parent of the country” and refers to the traditional role of the state as sovereign and guardian of persons with a legal disability to protect their health and welfare, especially for mentally disabled persons and infants. See BLACK’S LAW DICTIONARY 1114 (6th ed. 1990).*

6. Competence is a legal and philosophical concept, not necessarily a clinical methodology for assessment. Courts decide whether a person is “competent” or “incompetent” to exercise legal rights; clinicians and other experts devise methods to demonstrate whether a person had adequate abilities to make appropriate decisions. See Elyn R. Saks, *Competency to Refuse Psychotropic Medications: Three Alternatives to the Law’s Cognitive Standard*, 47 U. MIAMI L. REV. 689, 692-94 (1993). Yet, the law also delegates responsibility to attorneys and physicians to make determinations of a person’s mental competence. Before physicians obtain “informed consent” for any major medical procedure, the physician must first determine if the patient has a sound mind to give it. See Robert P. Roca, *Determining Decisional Capacity: A Medical Perspective*, 62 FORDHAM L. REV. 1178, 1190 (1994). For attorneys, there is an obligation to determine whether a client is competent in order to represent him “zealously,” or incompetent, which makes a search for a decision-maker necessary and a “best interests” representation appropriate until one is found. See American Bar Association Code of Ethics, § 7.
permitted people to do potentially hazardous and deadly activities without the ability to appreciate the risks or consequences. Of course, protection from such decision-making incompetence is most clearly and universally applicable to children of minor age, who have historically been closely protected and considered per se unable to make certain decisions such as marriage, contracting, sexual practices, and consenting to medical care, until the age of adulthood.7

For a person capable of moral and behavioral judgments, the question of whether he or she behaved responsibly was a question that would be addressed by the criminal or civil law. However, someone incapable of responsible acts might not be answerable to the law or society. Following Greek and Roman law, the common law subsequently developed what can be called "absolving conditions" of civil law and "excusing conditions" of criminal law.8

Civil law absolutions included removal of the rights and forgiveness of the obligations of contract, marriage and testamentary gifts. These were "absolving conditions" of civil law because they removed existing responsibilities that were already encumbered or that the law would otherwise have imposed in terms of contract, testamentary gifts, and marriage. The criminal law excuses a person from standing trial, exonerated culpability through the insanity defense, and prohibited execution. These conditions totally excuse ab initio the person from any obligation, even to participate in legal proceedings. The inability to stand trial means results in no trial. Insanity during the commission of a crime precludes assignment of criminal culpability. Insanity, even after a verdict, prevents the defendant from capital punishment.9

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7. There have been exceptions to this doctrine in recent years, generally known as the "mature minor" doctrine. Under it, children of minor age are given limited rights to consent to certain types of medical care, such as testing for sexually transmitted diseases, mental health care, contraception and abortion. See generally Joan-Margaret Kun, Rejecting the Adage "Children Should be Seen and Not Heard": The Mature Minor Doctrine, 16 PACE L. REV. 423 (1996).


9. See WILLIAM A. CARNAHAN & JACK ZUSSMAN, MENTAL HEALTH: NEW YORK LAW AND PRACTICE, passim Chapters 14-22 (1976). These categories of "absolving" and "excusing" conditions are an heuristic created by the author. They are not discussed as such in this two volume work, but rather are distilled from the theoretical framework of legal rights of the mentally dis-
Greek mythology tells a story of what could be the first “insanity defense.” In the myth called *The Madness of Hercules the Strongman and Adventurer*, Hercules, as one of the numerous illegitimate, demigod progenies of Zeus, the King of the gods, is driven insane by Zeus’ wife and kills his own family. During his lifetime, Hera, Zeus’ wife, hounded and hunted Hercules because Hercules very existence, as the illegitimate offspring of her husband, shamed her. Hera wanted to destroy Hercules as a living symbol of Zeus’ infidelity. She cast a spell of madness upon Hercules, which caused Hercules to kill his wife and three children, despite his total devotion to them. After this horrible spectacle, witnessed by the townspeople, Hercules was so bewildered that he had no inkling of what happened to his family. But, when he learned the truth that he killed them himself, he said, “[A]nd I myself am the murderer of my dearest.” As a result of this realization he became suicidal. Yet, the townspeople stopped him by saying, “[Y]ou were out of your mind.” The community believed that Hercules was not responsible and Hercules eventually returned to sober reason and sorrowful acceptance of his fate due to the friendship and caring of the community:

Theseus, the thinker, rejected the idea that a man could be guilty of [M]urder when he had not known what he was doing and that those who helped such a one could be reckoned defiled. The Athenians agreed and welcomed the poor hero. But [Hercules] himself could not understand such ideas. He could not think the thing out at all; he could only feel. He had killed his family.

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8. See also *The Insanity Defense in New York*, A Report to Gov. Hugh L. Carey (William A. Carnahan ed., 1978). Although guardianship is a long recognized power of the state that can be imposed on children of minor age or the mentally disabled, it is neither an absolving nor an excusing condition of law. Rather, guardianship is a fiduciary relationship meant to preserve autonomy or the enjoyment of legal rights and privileges notwithstanding the decision-making impairment due to age or illness. Thus, it should also be noted that civil commitment of the mentally ill can be considered a form of guardianship by the state pursuant to its *parens patriae* powers. *Foucha v. Louisiana*, 504 U.S. 71, 103 (1992) (Thomas, J. dissenting, uses this concept, saying: “Insanity, in other words is an affirmative defense that does not negate the State’s proof, but merely ‘exempt[s] the defendant from criminal responsibility.’”).

11. *Id.*
Therefore, he was defiled and a defiler of others.\textsuperscript{12}

This story provides an early example in Western thought and culture of one of the "excusing" conditions later found in criminal law. It is also happens to be an example of the \textit{parens patriae} power of the community that offered care and treatment and refused to punish Hercules. Although Hercules perpetrated criminal acts, the community excused Hercules from the consequences because he committed the crimes without knowledge or volition due to mental illness.

Both Roman and English law provide examples of mental illness in mitigating punishment. Ancient Roman law contained both "excusing" conditions of the criminal law and "absolving" conditions of civil law, both based on mental disability. The absolving conditions in Roman law covered contract, marriage, and testamentary gifts. Roman law also provided for guardianship to provide a substitute decision-maker through a government magistrate ("curator") for persons who were mentally disabled.\textsuperscript{13} Under English law, the King, as sovereign, was the legal guardian of all "lunatics" and "idiots."\textsuperscript{14} For a person deemed insane, the King became the guardian of the person and his property, but was obliged to relinquish control back to the person upon the return or restoration of his sanity.\textsuperscript{15}

Over the last two centuries, philosophy and law has seen the enhancement of personal autonomy and rights that are granted and protected by the government. Consistently throughout this time period, the law predicated the legitimate exercise of personal and property rights upon sanity, or having a sound mind. Generally, the legal term for this is "competency." Being "mentally incompetent" meant that a person theoretically had a personal or property right, but did not have the physical or mental capacity to exercise such rights with the level of responsibility that society required in its laws and customs.\textsuperscript{16} Accordingly, absence of "sound mind" has been justification for a loss of liberty, or a loss of the enjoyment of property.

\begin{enumerate}
\item\textsuperscript{12} Id. at 162-63.
\item\textsuperscript{13} See SAMUEL J. BRAKEL et al., THE MENTALLY DISABLED AND THE LAW 9-10(1985).
\item\textsuperscript{14} Id.
\item\textsuperscript{15} See id. at 10.
\item\textsuperscript{16} "Legal incapacity": This expression implies that the person in view has the right vested in him, but is prevented by some impediment from exercising it; as in the case of minors, committed persons, prisoners, etc. BLACK'S LAW DICTIONARY 760 (6th ed.).
\end{enumerate}
The concept of mental competency required for the exercise of personal rights was an unarticulated premise of eighteenth century Enlightenment and American pre-Revolutionary thought. The concept implied that a person could be held responsible for his actions because he had the potential or ability to act responsibly. In this regard, both the U.S. Constitution and Declaration of Independence reflect Scottish and French eighteenth century Enlightenment thinking.

In the United States, legal competency generally consists of three elements: knowledge, reasoning, and voluntariness. These basic elements are found in Aristotle's works, where he defines their true nature by the characteristics that distinguished them.

Acts just and unjust being as we have described them, a man acts unjustly or justly whenever he does such acts voluntarily; when involuntary, he Acts neither unjustly or justly except in an incidental way; for he does things which happen to be just or unjust. Whether an act is or is not one of injustice (or of justice) is determined by its voluntariness or involuntariness; for when it is voluntary it is blamed, and at the same time is then an act

19. See Godinez v. Moran, 509 U.S. 389, 400-402 n. 12 (1993); see generally Loren H. Roth et al., Tests of Competency to Consent to Treatment, 134 Am. J. Psychiatry 279 (1977); see also Paul S. Appelbaum & Thomas Grisso, The MacArthur Treatment Study I: Mental Illness and Competence to Consent to Treatment, 19 L. & Hum. Behav. 105, 110 (1995). These articles and studies use somewhat different formulations of the legal elements of competence or ability to consent. Despite most of the variations, they can all be essentially reduced into the three classic elements of knowing, intelligence, and voluntariness. For example, the well-regarded MacArthur study adds a further element to these three, described as "appreciation" by the patient of the mental illness and possible treatment. Although clearly "appreciation" had statistical significance in terms of refining patient characteristics, it nonetheless can surely be considered a subdivision of intelligence, i.e. the ability to reason. See Kathleen Cranley Glass, Refining Definitions and Devising Instruments: Two Decades of Assessing Mental Competence, 20 Int'l J.L. & Psychiatry 5, 12 (1997). Other variations in these formulations specify obvious or implied requirements such as the ability to communicate that decision to others and the necessity that the medical treatment provider knows about the personal choice.
of injustice; so that there will be things that are unjust but not yet acts of injustice, if voluntariness be not present as well. By the voluntary I mean, as has been said before, any of the things *in a man’s own power which he does with knowledge*, i.e., not in ignorance either of the person acted on or of the instrument used or of the end that will be attained.  

Thus, the existence of a rationale mind distinguished mankind from other animals, thus defining mankind as the “rational” animal. Aristotle further postulates that the idea of justice, based on individual responsibility, originated in a person’s decision-making competency. Without it, a man could not act responsibly, and therefore could not be held responsible.

The Enlightenment philosophers revived Aristotelian thought and weaved it into the fabric of legal thinking in England, France and the United States. For example, Rousseau believed that autonomy of the person was a matter of the grand Social Contract, whereby each person submits to norms freely as a member of the community. This idea was expressed by Cicero, who stated that “[c]itizens are self-obedient to the rule of law in the social contract so that they may be free within the order that is created.” The Social Contract is a balance in the sense that a citizen who is unable to exercise legal rights due to mental disability is not only absolved or excused from legal obligations, but is also eligible for treatment or custodial care from the government as “parent of the country” under natural law concepts. The authority of governments in Western thought and culture, and one inherent in the laws of the United States, is not only to care for persons with an inability to make decisions, but also to nurture and encourage that decision-making process where it is feasible. As guardian-at-large for children and mentally incompetent persons, to promote

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22. See GIOVANNI SARTORI, DEMOCRATIC THEORY 298 (1962).
23. “Legum servi sumus ut liberi esse possimus.” Oratio pro Cluentio; Aristotle wrote: “Men should not think it slavery to live according to the rule of the constitution; for it is their salvation. (Politics 1310a). Id. at 288, 316 n. 19, 22.
treatment of individuals and enhance public safety, governments have established surrogate decision making systems to promote autonomy among its citizens. Originally, it was the King or his appointee. Now the courts play this role in situations of excusing and absolving conditions of both civil and criminal law, such as nullifying a contract, a marriage, consenting for major medical procedures, etc.

In terms of fundamental principles of American jurisprudence, John Locke is considered one of the most influential pre-Enlightenment thinkers. Locke accurately analyzed the jurisprudential principles of surrogate decision-making in the context of the parental obligation to children and the government’s obligation for those adults with decision-making incapacity:

The Power, then, that Parents have over their Children, arises from that Duty which is incumbent on them, to take care of their Off-spring, during the imperfect state of Childhood. To inform the Mind, and govern the Actions of their yet ignorant Nonage, till Reason shall take its place, and ease them of that Trouble, is what the Children want, and the Parents are bound to. For God having given Man an Understanding to direct his actions, has allowed him a freedom of Will, and liberty of Acting, as properly belonging thereunto, within the bounds of that Law he is under. And so Lunaticks and Ideots are never set free from the Government of their Parents; Children, who are not as yet come unto those years whereat they may have; and Innocents which are excluded by a natural defect from ever having; Thirdly, Madmen, which for the present cannot possibly have the use of right Reason to guide them-

25. "Locke was the great practical success; the new English and America regimes founded themselves according to his instructions... The notion that man possesses inalienable natural rights, that they belong to him as an individual prior, both in time and in sanctity to any civil society, and that civil societies exist for and acquire their legitimacy from ensuring those rights, is an invention of modern philosophy... Hobbes initiated the notion of rights, and it was given its greatest respectability by Locke... [T]he whole world is divided into two parts, one of which traces its intellectual lineage back to Locke and the other to Marx, and the latter is much readier to acknowledge its parent than is the former." ALAN BLOOM, THE CLOSING OF THE AMERICAN MIND 162, 165, and 217 (1987); Historian Louis Hartz holds that Locke: "dominates American thought as no thinker anywhere dominates the political thought of a nation." LOUIS HARTZ, THE LIBERAL TRADITION IN AMERICA 140 (1955).
selves, have for their Guide, the Reason that guideth other Men which are Tutors over them, to seek and procure their good for them, says Hooker, Eccl. Pol. Lib. 1, Sect. 7. All which seems no more than that Duty, which God and Nature has laid on Man as well as other Creatures; to preserve their Off-Spring, till they can be able to shift for themselves, and will scarce amount to an instance or proof of Parents Regal Authority.  

Legally and culturally, sanity was based on the capability of right reason.  

This Lockean idea has been long considered part of the historic power of the states’ obligation “to protect persons under legal disabilities to act for themselves [and] to act as the “general guardian of all infants, idiots and lunatics.” Yet the state not only has an obligation of care in restoring citizens to rational thought under its *parens patriae* power, but also has an interest in promoting, and in some cases requiring the rational behavior of citizens by imposing sanctions for unreasonable behavior. The King’s *parens patriae* powers were exercised in the courts of equity, powers which evolved from the ecclesiastical courts of the Roman Catholic Church. These courts of equity exercised jurisdiction to decide if a person was either mentally ill (known as being “mad” or a “lunatic”) or mentally retarded (“idiot”), thereby designating the king to provide care for the person or the person’s estate. For those found incompetent due to mental illness, control of the estate returned to the individual once he regained sanity.

Implicit in evolving American constitutionalism during the late-eighteenth century is the Enlightenment’s unarticulated premise that mentally incompetent citizens were not denied their rights as a citizen. For without the ability to reason, to exercise responsibility or to make intelligent choices, exercising liberties made no sense. Rather, such persons needed protection from the hazards and consequences of self-execution of their rights. The law did not permanently deny such

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26. **JOHN LOCKE, TWO TREATISES OF GOVERNMENT** 348-352 (Peter Laslett ed., 1965) (written approximately 1690, although there is some dispute within a three-year period).


28. *The Late Corp. of the Church of Jesus Christ of Latter-Day Saints v. United States*, 136 U.S. 1, 57-58 (1890); *Standard Oil Co.*, 405 U.S. at 257 (1972).
rights, but rather postponed the exercise of rights or transferred them to surrogates or fiduciaries acting in the person’s best interests. Legal rights were inextricably linked to social responsibility, and the inability to act responsibly inherently necessitated the invocation of the police power or parental power of the state.

By the mid-nineteenth century, John Stuart Mill, in his essay *On Liberty*, had finally articulated the theretofore unarticulated Enlightenment premise that a person must be capable of rational decision-making in order to exercise liberty:

> That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forebear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part, which merely concerns him, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.  

Some commentators use Mill’s statement to argue that a future commitment to restore competency does not increase liberty, but rather represents a form of “self-paternalism.” This distorts Mill’s philosophy by taking it out of an important context that appears in the subsequent sentence. It contains Mill’s caveat that the limits on the


state’s compulsory power is predicated on a person being a mature adult who has soundness of mind. “It is perhaps hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties.”

It was assumed by most seventeenth to nineteenth century European thinkers, such as Hegel, Kant, Rousseau, Locke, and Mill, that the concept of liberty by definition involves a rational or intelligent choice based upon enlightened self-interest to be able to act responsibly. Legal rights did not have meaning to persons who were mentally impaired and unable to make rational decisions. This applied universally to a minor-aged child per se. This state was equated in law, as it is today, to someone with a judgment-impairing mental disability. How can someone exercise liberty if incapable of rational decision-making? How can it be a “massive deprivation of liberty” if the state seeks to restore a person’s ability to exercise decision-making and liberty, or undertakes to assist someone, parens patriae, to exercise decisions in his or her best interests?

To the pragmatists, and the early natural law adherents who helped frame the Constitution, there was virtually absolute liberty to think and express any thoughts, no matter how irrational. However, no right existed to act irrationally. Responsibility and freedom based upon a person’s free will and sanity were inextricably linked in thought and law. This formed the common view of the founding fathers and the political thinkers of that time, such as Dr. Benjamin Rush, a signer of the Declaration of Independence, member of the Constitutional Convention, and father of American psychiatry. He expressed the view of that era by describing a person with serious mental illness as “incapable of acting either freely, or from necessity . . . they have no will of their own. This is strictly true.”

31. See THE ENGLISH PHILOSOPHERS, supra note 29, at 956.
32. See Mike Startup, Awareness of Own and Others Schizophrenic Illness, 26 SCHIZOPHRENIA RESEARCH 299-304 (1997).
33. Benjamin Rush, DISEASES OF THE MIND 268-69 (originally published in 1812) (The Classics of Medicine Library 1979). Dr. Rush, as both a psychiatrist and political thinker of the times, stated, “Let it not be said, that confining such [mentally ill] persons in a hospital would be an infringement upon personal liberty, incompatible with the freedom of our governments.” Id. at 267. Dr. Rush also believed in due process of law, adding: “To prevent injustice or oppression, no person should be sent to the contemplated hospital, or Sobber House, without being examined and committed by a court.” Id. at 268.
With Locke, Mill and other kindred thinkers of the era, there existed a belief in an unreserved right to think and speak. However, as Mill said, "[n]o one pretends that actions should be as free as opinion. . . . The liberty of the individuals must be thus far limited; he must not make himself a nuisance to other people." This belief, that there existed a relationship between individual rights and society’s rights was not mutually exclusive, but rather a balance. He continued:

No person is an entirely isolated being; it is impossible for a person to do anything seriously or permanently hurtful to himself without mischief reaching at least to his near connections, and often far beyond them. . . . If he deteriorates his bodily or mental faculties, he not only brings evil upon all who depend on him for any portion of their happiness, but disqualifies himself for rendering the services which he owes to his fellow-creatures generally; perhaps becomes a burden on their affection or benevolence; and if such conduct were very frequent, hardly an offense that is committed would detract more from the general sum of good. . . . And even (it will be added) if the consequences of misconduct could be confined to the vicious or thoughtless individual, ought society to abandon to their own guidance those who are manifestly unfit for it? If protection against themselves is confessedly due to children and persons under age, is not society equally bound to afford it to persons of mature years who are equally incapable of self-government? . . . There must be some length of time and amount of experience after which a moral or prudential truth may be regarded as established: and it is merely desired to prevent generation after generation from falling over the same precipice which has been fatal to their predecessors.

Accordingly, Mill said that "[n]o person ought to be punished for being drunk; but a soldier or a policeman should be punished for being drunk on duty." An identical principle forms the basis for the United States Supreme Court’s decision in Powell v. Texas. The Court held that while one could not constitutionally be punished for being a

34. The English Philosophers, supra note 29, at 992.
35. Id. at 1012.
36. Id.
drunk, the state has a right to punish uncontrollable drunkenness that offends the public order.\textsuperscript{38} Justice Thurgood Marshall, writing without dissent, gave tacit recognition to the work of philosophers such as Aristotle, Locke and Mill. He wrote:

We cannot cast aside the centuries-long evolution of the collection of interlocking and overlapping concepts, which the common law has utilized to assess the moral accountability of an individual for his antisocial deeds. The doctrines of \textit{actus reus, mens rea}, insanity, mistake, justification, and duress have historically provided the tools for a constantly shifting adjustment of the tension between the evolving aims of the criminal law and changing religious, moral, philosophical, and medical views of the nature of man.\textsuperscript{39}

There is a strong public interest for the state to elicit promises from certain individuals to continue their course of medical treatment. Behaviors in public subject to reasonable state control include not only dangerous or hazardous ones, but also those that might generally offend the "moral and esthetic sensibilities of a large segment of the public."\textsuperscript{40} If a state can punish an individual for permitting his condition to become uncontrollable, socially unacceptable behavior in public, surely it can use non-criminal civil law powers to persuade mentally ill individuals, already receiving treatment in the community, to take medically acceptable steps to control their behavior.

\section*{II. PSYCHIATRIC CONTEXT}

The use of the term "intermittently mentally ill" refers to an indistinguishable group of persons with severe mental illness who are capable of living in the community with support, but who periodically experience mental decompensation, loss of decision-making ability, impairment

\begin{itemize}
\item[38.] See \textit{id.} at 535.
\item[39.] \textit{Id.}
\item[40.] "[Texas] has imposed upon appellant a criminal sanction for public behavior which may create substantial health and safety hazards, both for appellant and for members of the general public, and which offends the moral and esthetic sensibilities of a large segment of the community. This seems a far cry from convicting one for being an addict, being a chronic alcoholic, being mentally ill or a leper . . . ." \textit{Robinson v. California}, 370 U.S. 660, 666 (1962).
\end{itemize}
of insight into the onset of their illness, or a lack of appreciation for their need of treatment. Most such individuals, with proper counseling, appropriate psychiatric treatment, and an appropriately drafted mental health advance directive, can be given a self-guardianship of their condition even during periods of mental decompensation. The Nexum incorporates the concept of a mental health advance directive now found in the laws of twelve states, but goes beyond its unilateral nature by adding both a promise of loyalty from the treatment system, as well as an outstanding alternative dispute resolution system to instill patient trust in the system. With this option, many individuals can maintain greater control over their lives, obtain more effective and inexpensive care, while avoiding the trauma and other disadvantages of rehospitalization. Also avoided are court adjudication of incompetency, and perhaps, slipping into the criminal justice system. And, there are positive quid pro quo's that show how building patient trust encourages participation, reinforces a therapeutic alliance, minimizes conflict, and maximizes cooperation where there is mutuality of trust, understanding, and appropriate treatment.

After two centuries of institutionally based care, and the dramatic changes in the last four decades of moving from institutional care to community based programs in mental health treatment, the beginning of the Twenty-First century is an appropriate time to call for a new paradigm of patient rights to obtain and select among a variety of appropriate levels of patient care. Because of new medications and the establishment of a greater variety of community programs, the paradigm should no longer focus on the chronic or long-term hospitalized patient, but rather the "intermitently mentally ill" patient. This rec-


42. Chronic mental illness often ebbs and wanes in terms of debilitating systems. Here, the new paradigm will be called the "Intermitently Mentally Ill" patient (IMI), meaning a person with a controllable level of mental dysfunction who is able to live safely in the community. As modern psychiatric medications have reduced the severity of psychosis to permit treatment in the community, it has concomitantly created a new problem for the severely mentally ill patient. Without the supervision afforded in an institution, many patients have found it difficult to maintain a medication regimen. The consequence is the IMI patient who can sustain existence in the community with proper support as long as therapeutic medications control psychotic symptoms and prevent serious mental destabilization. This concept has also been termed "the revolving-door syndrome." See Gustavo A. Fernandez & Sylvia Nygard,
ognizes the new and largely welcomed scientific advances that now provide the clinical support necessary to patients with severe mental illnesses and sustain them in their own community with the dignity of controlling their treatment to a reasonable degree.

It is well known that many seriously mentally ill patients, however, present a problem of periodically regressing to a dysfunctional level of psychosis. This condition is not really chronic in the sense of being randomly uncontrollable for long periods. Rather, with proper advanced planning to ensure proper medication or other help, the person is only "intermittently mentally ill," in the sense of an ability to sustain long periods of outpatient treatment and freedom. The intermittently mentally ill person still faces the risk of occasional relapse due to a failure to continue medication, a failure of that medication, or other factors which destabilize an individual's mental state. But, if a Nexum agreement exists, such relapses or deteriorating mental faculties can often be planned for by the person himself, based on prescriptive behaviors or recognizing behaviors that have already occurred in the cycles of the mental illness.

Congress has made advance directives a national priority because they serve both the public and the patient's interests. Even if the relapses cannot be predicted with certainty, a plan can minimize pain, suffering, and loss of autonomy. Most of these episodes of severe relapse are due to a failure of psychotropic medication to control the symptoms of the disease. This usually includes a significant impairment of insight by the person into his own deterioration to either seek or consent to treatment. Further risks can, and usually do, include a serious inability to cope with the hazards faced in the community (such as harsh seasonal conditions, predatory individuals, getting medical

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Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina, 41 HOSP. & COMM. PSYCHIATRY 1001, 1002 (1990). However, this term seems not only pejorative but also fatalistic, implying that regular relapses among the mentally ill are inevitable and regular. Indeed, it harkens back to the term "lunatic" which also implied regularity of the mental illness as in the phases of the moon. In contrast, the IMI paradigm implies that with proper assistance in preparing for such relapses, especially with advance directives, they can be minimized in frequency and quickly arrested from becoming worse. This will minimize patient and social costs and maximize autonomy and available resources for treatment. Ironically, the IMI concept is closer to the now archaic term "lunatic" that implied undifferentiated mental illness that was related to (and caused by) the moon's influence.
care, etc.), permanent or irretrievable deterioration of mental condition, posing risks to others and possible institutionalization if civil commitment must be sought.

Characteristics of the intermittently mentally ill can be empirically identified. This identification is fundamentally a function of the lessening of insight or awareness into their disease. In a downward spiral, this leads to the deterioration in both mental and physical health due to the cessation of psychotropic medications and a dire need for a more structured treatment environment. Kraepelin first described the phenomenon of lack of insight in noticing that: “The patients have, at first at least, no real understanding of the gravity of the disorder... [they] give as answers explanations that say nothing.” Older textbooks of psychiatry only slightly refer to this concept of insight other than in psychoanalysis, the most influential modality of treatment at the turn of Twentieth Century. Some studies show that even though a patient could distinguish between psychotic symptoms, while in others, insight into a patient’s own condition remained impaired. This suggests that delay or interrupted treatment produces less insight or more insight deterioration in a subgroup of chronically impaired pa-

43. “The phenomenon of poor insight is defined as a general lack of awareness of having a mental disorder or needing treatment, for example, psychotropic medications. Contemporary definitions of insight regard this phenomenon as occurring on a continuum which can be assessed by skilled clinicians. Thus, insight can be reliably measured using ratings on standardized instruments. Using standardized scales, researchers have found that ratings of poor insight in schizophrenia are associated with lack of compliance in taking medications, refusal of treatment regimens, poorer over-all recovery after treatment, an increased risk of psychological decompensation, a greater number of rehospitalizations, poorer long-term outcome and worse over-all treatment outcome.” See Robert C. Schwartz, Symptomatology and Insight in Schizophrenia, 82 PSYCHOLOGICAL REP. 227, 228 (1998); Shmuel Fennig, et al., Insight in first-admission psychotic patients, 22 SCHIZOPHRENIA RES. 257, 261-62 (1996). See also Akihiro Takai, et al., Insight and its Related Factors in Chronic Schizophrenic Patients: A Preliminary Study, 6 EUR. J. PSYCHIATRY. 159, 167 (1992).


Conversely, amelioration of psychotic condition consistently yielded improvement in insight, especially concerning previous illness episodes. Studies estimate that between fifty-seven and eighty percent of persons with serious mental illness can have moderate or severe impairment in their insight. Insight into having an illness, however, may be less important than an awareness of the previous efficacy of pharmacotherapy because awareness of previous positive outcomes can be more predictive of compliance, acceptance of diagnosis, and awareness of the higher quality of life when the individual is healthy.

These studies show that schizophrenia affects the cognitive function of the brain that controls a person's self-awareness of the disease. Additional studies conclude that there is brain dysfunction on a continuum in terms of metabolism, cognition, neurology, and eye tracking in persons with schizophrenia and that it is found in most affected individuals to one degree or another. Moreover, the disease profoundly affects personality. Based on scientific research made possible by new technology that can track brain functions like never before, scientists increasingly view schizophrenia and bipolar affective disorders as organic in origin, causing brain pathology.

47. See April A. Collins et al., Insight, Neurocognitive Function and Symptom Clusters in Chronic Schizophrenia, 27 SCHIZOPHRENA 37, 42 (1997).
50. See Amador and Seckinger, supra note 44, at 804.
51. See E. Fuller Torrey ET AL., SCHIZOPHRENA AND MANIC DEPRESSIVE DISORDER 143-49 (1994).
52. See, e.g., Thomas J. Raedler et al., Schizophrenia as a Developmental Disorder of the Cerebral Cortex, 8 CURRENT OPINION IN NEUROBIOLOGY 157 (1998); Michael B. Knable & Daniel R. Weinberger, Dopamine, the Prefrontal Cortex and Schizophrenia, 11 J. OF PSYCHOPHARMOCOLOGY 123, 124 (1997); Michael B. Knable & Daniel Weinberger, Are Mental Diseases Brain Diseases? The Contribution of Neuropathology to Understanding of Schizophrenic Psychoses, 245 EUR. ARCHIVES PSYCHIATRY CLINICAL NEUROSCIENCE 224, 225 (1995).
These negatively reinforcing conditions and symptoms make treatment and gaining consent very difficult. The majority of patients who lack insight, awareness or consciousness of their disease, are indifferent to it and reject the need for treatment. This is logical to such persons — if you sincerely think you are not ill, why would you seek or submit to treatment? Thus, the patient will deny having any disease, refuse to acknowledge any symptom, and feel it is appropriate to refuse treatment. Indeed, this usually manifests itself as belligerency towards both the treatment and the individual supplying the treatment. This belligerency manifests itself in the dilemma that persons who do not know of their illness cannot adequately make the decision to refuse treatment, thereby affecting any possibility of restoring their decision making ability.

Conversely, there is a strong correlation between a person’s self-awareness and insight into the illness of schizophrenia and seeking and consenting to appropriate ameliorative treatment:

Common sense suggests, and research studies confirm, that the mentally ill with greater insight into their condition are more likely to seek psychiatric help when they become sick and also to comply with treatment regimens. . . . Another study found that persons with


54. “Most medical professionals do not question the competence of a patient who is consenting to treatment. This may be due to the clinician’s unwillingness to question a patient’s autonomy when the physician reasonably believes the patient is agreeing to a procedure that is in his or her best interests. On the other hand, it has been argued that rejection of treatment may function as a useful indicator of the need for a competence assessment. That is to say, only patients who are making choices that, in the judgment of the clinicians, threaten their medial welfare should be subjected to rigorous examination of their capacity to make decisions.” Jessica Wilen Berg, et al., Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions, 48 RUTGERS L. REV. 345, 393 (1996). “All patients who refuse treatment are not per se incompetent nor should formal screening mechanisms be applied to all consenting patients, but rejection can be used as a means of identifying those patients whose competence should be examined further.” Id.
schizophrenia who had impaired insight were less likely to comply with the demands of a work rehabilitation program. . . . Impaired insight is the single most important reason why the mentally ill do not take medications regularly and is thus the most important cause of relapse. 55

There is evidence that the ability of patients to exercise a right to informed consent after they become acutely psychotic, particularly in cases of schizophrenia, is generally open to serious doubt, especially when they are taking or offered anti-psychotic medication. 56 One study recommended that "[t]he patient's verbal assent to treatment, supplemented with a proxy consent obtained from friends, relatives, or committees, may be a more rational alternative to present consent procedures that emphasize form over content." 57 These issues should clearly be decided, for both patient and the physician in the context of a Nexum agreement. Which would enhance the coordination of treatment as well as reduce duplication, and produce a workable treatment plan. Thus, the Nexum produces, a new form of mental health advance directive proposed, allows the physician to act as the mediator, if necessary, and to include whomever will help in this effort. 58

The Nexum will personally involve the physician and become a show of commitment to the patient. The effectiveness of mental health treatment is proportional to the amount of genuine patient cooperation and acceptance of physician advice. 59 When physicians participate,

55. Torrey, supra note 2, at 155.
56. "This study indicates that psychotic patients, particularly those with prominent thought disturbance, do not substantially understand information about antipsychotic medication. Meaningful informed consent in which the psychiatric patient learns about his or her illness, its treatment, and possible risks (for example tardive dyskinesia), may need to be delayed for the acutely disturbed hospitalized patient until disorganization of thought can be treated with antipsychotic medication." Michael Irwin et al., Psychotic Patients Understanding of Informed Consent, 142 AMER. J. PSYCHIATRY 1351, 1354 (1985).
57. Id.
and give patients explanations and choices in the process, adherence by patients increases.\textsuperscript{60} Self-guardianship over one's periods of incompetence would promise the patient intrinsic control and motivate the patient to participate. It would largely obviate objections to treatment and transfer any residual objection at the time of rendering treatment to an administrative panel consisting of a member with direct knowledge and experience of mental illness, unlike most members of the judiciary.

III. DEINSTITUTIONALIZATION AND THE MODERN LEGAL CONTEXT

"Deinstitutionalization" represents one of the most profound social movements in late twentieth century American history. Based on new developments in medical treatment, it ends a period of at least two centuries of English and American treatment of the mentally ill based on the idea that persons with severe mental illness should be cared for in an asylum. In 450 B.C., Hippocrates, a Greek physician, became one of the first to believe that mental illness was a disease in the sense of being caused by natural phenomena. He proposed the asylum as a retreat to remove the stress and impurities of life that were thought to exacerbate mental disorders.\textsuperscript{61}

Modern terminology has often changed names for the asylum, from "institutions" to "facilities for the mentally ill," probably as a way to mask the constant problems and abuses occurring in them. Yet, for all their failings, the asylums provided state of the art treatment and protection to patients with severe mental illness who would otherwise suffer the hazards of living in society and the hostilities of the general public toward persons with mental disabilities.\textsuperscript{62}

In the 1950's pharmacology produced its most dramatic results: symptom-suppressing, neuroleptic drugs. For the first time, these new drugs permitted patients to adequately function outside the close supervision of the institution. Along with this change came the increas-

\textsuperscript{60}. DAVID B. WEXLER & BRUCE J. WINICK, ESSAYS IN THERAPEUTIC JURISPRUDENCE 68-74 (1991).

\textsuperscript{61}. See Brakel, supra note 13, at 9.

\textsuperscript{62}. See PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 72-76 (1982).
ingly high cost of operating institutions and changes in civil rights laws and policy, which in turn spurred changes in government policies and funding. The result was a massive shift in the venue for care and treatment, resulting in almost 500,000 people being released from the care and security of the institution to greater responsibility and freedom in the community.\(^6\)

The magnitude of deinstitutionalization of the severely mentally ill qualifies it as one of the largest social experiments in American history. In 1955, there were 558,239 severely mentally ill patients in the nation’s public psychiatric hospitals. In 1994, this number had been reduced by 486,620 patients, to 71,619. . . . It is important to note, however, that the census number of 558,239 patients in public psychiatric hospitals in 1955 was in relationship to the nation’s total population at the time, which was 164 million. By 1994, the nation’s population had increased to 260 million. If there had been the same proportion of patients per population in public mental hospitals in 1994 as there had been in 1955, the patients would have totaled 885,010. The true magnitude of deinstitutionalization, then, is the difference between 885,010 and 71,619. In effect, approximately 92 percent of the people who would have been living in public psychiatric hospitals in 1955 were not living there in 1994.\(^4\)

Despite these social changes, the federal government’s enthusiasm for rapid change, especially during the administration of John F. Kennedy, was not matched by workable practices and available funding.\(^5\) Deinstitutionalization began initially with initiatives of the executive branch of the federal government, with state governments following shortly thereafter. Two decades later, the judiciary began to play an important role in shaping the course of treatment by requiring legal procedures and conditions for rendering care and treatment. Many of these requirements were the result of horrible scandals that pockmarked

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\(^{6}\) TORREY, supra note 2, at 8-9; Allan D. Miller, Deinstitutionalization in Retrospect, 57 PSYCHIATRIC Q. 160, 169 (1985).

\(^{4}\) Id.

\(^{5}\) Daniel Patrick Moynihan, Defining Deviancy Down, 61 AMERICAN SCHOLAR 17 (1993); see also The Care of the Mentally Ill in the State of New York, A Report by a Commission appointed by Honorable Thomas E. Dewey Governor of the State of New York (1944).
the landscape of institutional care continually. 66

A large, well-organized cohort of public interest lawyers carried on this litigation. 67 Based in part on reaction to scandals and a growth in so-called “public interest law,” the lawyers worked vigorously to accelerate the demise of the state-based institutional care system. In the early 1970’s, many of these lawyers began litigation aimed at destroying government reliance on both the institutional care system and the paternalism inherent in its pervasive control of patient’s lives. Lawsuits were brought with the aim of minimizing or eliminating institutionalization of the mentally ill by successfully suing to obtain judicially mandated procedures similar to those in criminal law. The hope was that intensive crypto-criminal due process requirements would make it so difficult and expensive for government to involuntarily commit patients for care and treatment that efforts to do so would be slowed down or largely abandoned. 68 Yet, this litigation was counter-productive from the patients perspective because it destroyed whatever sanctuary the asylum provided. Unfortunately, the results have clearly been that persons discharged into the community with impaired decision-making lacked the skills to cope with the hazards of freedom thrust upon them. Sadly, the alternative to the asylum has increasingly become the prison. 69 These results made it more difficult

69. See C.G. Schoenfeld, Recent Developments in the Law Concerning the Mentally Ill: “A Corner-Stone of Legal Structure Lain in Mud”, 9 UNIV. TOL. L. REV. 1, 29 (1977). “In fact, well intentioned judges, lawyers, and legislators may well have paved a hellish road indeed for the mentally ill . . . The upgrading of standards of institutional care . . . coupled with the granting to mental patients the full panoply of procedural rights given to many criminal defendants . . . has resulted in many of the mentally ill actually becoming criminal defendants, or being abandoned in the inner city.” Id.; see also Department of Justice, supra note 2.
and expensive to treat the most severely ill patients, particularly when legal adversaries who represented these patients became a fixture of the legal landscape. In many states, courts assumed gratuitously supervisory jurisdiction over mental institutions rendering coupled judgments that would last for decades and would inevitably complicate, delay, and distort government programs designed to re-orient treatment systems. The lawyers focused on the rights to informed consent and freedom from exploitation. This included the right to be paid for institutional labor, which effectively eliminated patients’ ability to learn useful skills, such as growing fresh vegetables in facility gardens or other farming tasks. Most of all, these lawyers sought to make patients free, not only from experimental or potentially dangerous treatments, they also wanted the courts to recognize a general right to refuse treatment with psychotropic medication. These assertions of rights supplemented the claim for a right to an alternative to institutionalization.

On the national level, the United States Supreme Court began taking cases involving what is historically termed “involuntary treatment.” In O’Connor v. Donaldson, the Supreme Court made its

70. See Allan Miller, Deinstitutionalization in Retrospect, 57 PSYCHIATRIC Q. 160, 169 (1985).

71. Of the two most famous cases in which a court exercised federal supervisory jurisdiction over institutions, one lasted over two decades, NYS Association for Retarded Children v. Rockefeller, 393 F. Supp. 715 (E.D.N.Y. 1975), while the other was filed in 1970 and is still pending today. Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971) aff’d sub nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).


73. While it is beyond the purview of this article, the point must be made that the term “involuntary” is a misnomer for a person who is incompetent to make a decision. It can be argued that it makes little sense to call a patient’s objection to treatment “involuntary” after a court finds the patient is incompetent to make such a decision. Thus, there is legally speaking no volitional component in a person who cannot exercise “free will,” and treatment is not “involuntary” as such. As Aristotle wrote, a person who is not able to make rational decisions cannot act other than randomly. See Nicomachean Ethics, supra note 21, at 8. Thus, such treatment might be termed “assisted,” “avoluntary,” or “judicially ordered,” but it is not “involuntary” for a person who is
Self-Guardianship by Contract

The Court’s first major pronouncement of substantive due process in the mental health field. It was a very ambiguous, yet profound ruling. The Court’s holding appeared, and was understood by most legal experts, to undermine a state’s traditional parens patriae power over civil commitment patients by requiring all civil commitment cases to require proof of the patient’s dangerousness. The necessity to prove a patient is dangerous is of course the antithesis of the parental model of caretaking, i.e., parents do not render care only when their children are in danger. This was one of the first nails in the coffin of the “medical model,” where the decision to treat a mentally ill person could be based on three classic elements: (1) the patient having a mental illness; (2) his lack of insight; and (3) the suitability of treatment or the need for custodial care. Despite this holding, courts were reluctant to completely eliminate short-term commitments based solely on the medical judgment of physicians.

Although O’Connor appears to establish a requirement for a finding of “dangerousness” in all compulsory treatment cases, it is equally likely that this pronouncement is merely dicta since dangerousness never became an issue in the case of the plaintiff’s initial commitment, nor was there any evidence that the patient himself was dangerous or faced danger during the fifteen years of hospitalization. The result of this decision was ambiguity with unanticipated negative consequences for treatment of the mentally ill. Now, instead of dangerousness being defined as facing a potential hazard not of the patient’s own creation, the O’Connor Court believed that dangerous can mean an inability to avoid dangers such as living in conditions of squalor, neglect, or failing to care for oneself. A young child is not considered “dangerous” legally incompetent.

77. See Paul F. Stavis, Involuntary Hospitalization in the Modern Era: Is “Dangerousness” Ambiguous or Obsolete? 41 QUALITY CARE 2, 3 (Aug.-Sept. 1989); see also Brakel, supra note 13, at 35 (“[T]he dangerousness language used by the Court was stated in the negative and primarily in response to the claim of a right to treatment.”).
when he tries to cross a busy street simply because he does not know how to do so safely. Rather, he is said to be "in danger," "endangered," or "unable to avoid danger." Yet this is the ambiguity in cases where civil commitment is clearly unwarranted, causing courts to mischaracterize and stigmatize otherwise innocent behavior as "dangerous." While part of the intent was to place the burden of erroneous determinations on the state treatment initiative, in such instances this might be a Hobbesian choice because the patient undoubtedly carries a substantial burden and risk of not receiving needed treatment.

The use of the dangerous criteria for compulsory treatment of the seriously mentally ill creates problems of loss of autonomy for the patient, as well as higher costs and lower efficiency of the mental health system. Perhaps, it might not be used at all. It is an essential and traditional function of government to prevent harm and violence caused by or clearly connected to a mental illness, and every state and most nations have laws to control it. Yet, it should not be a preferred criterion, only a necessary one.

If the O'Connor decision requires some element of "danger to oneself or others" in any compulsory treatment situation, then it injects uncertainty and less than reliable proof into the treatment process. To prove dangerousness is a dilemma, because either the person must have prior dangerous behavior, or if he or she has not, then proof necessarily becomes a prediction. It is senseless to talk about future behavior without actuarial data since all that can be somewhat reasonably predicted are the behaviors that might be the precursors of danger.


ous acts. To the extent that predicting dangerousness can be done with any precision, there is a high false positive rate with regard to any individual. Clearly, predicting future behavior that very likely will be dangerous is not a clinical activity, nor is it therapeutic in enhancing a beneficial alliance between the patient and doctor.

Further unintended consequences flowed from O'Connor. There are serious dilemmas for the patient: being falsely stigmatized as a dangerous person and failing to otherwise legally qualify for the parens patriae benefits of government sponsored treatment, or the fear of being left to deteriorate until reaching the point of real danger so the state can act. Proper parens patriae intervention obviously means that treatment should be rendered before a person deteriorates to the point of threatening his own life, health or ability to resume a healthy lifestyle. Subsidiary issues of how intense, how immediate, or how dire the danger must be to qualify were not addressed by the Court. Years later, the Court held that the level of proof for civil commitment and the element of proof concerning "dangerousness" must be by "clear and convincing" evidence. Given that psychiatrists are not particularly proficient in predicting dangerousness, there is an increased improbability that care could be rendered parens patriae to persons with serious mental illness.

The Court, having unintentionally undermined the traditional law of civil commitment, subsequently went on to cast doubts on more modern statutory developments that required treatment in the "least restrictive" or most voluntary setting. The case, Zinermon v. Burch, involved an injured and clearly delusional man, Darrell Burch, who

85. See Addington, 441 U.S. at 433.
87. See, e.g., N.Y. Mental Hygiene Law, § 31.23.
was found wandering on a Florida highway. 88 The Court found constitutional infirmity in the psychiatric hospital's failure to question and ultimately to refuse Burch's voluntary request for admission. This failure denied the patient the due process attendant to an involuntary judicial commitment proceeding. 89 Under these circumstances, the Court apparently failed to consider that the delay in the patient's amelioration that such a proceeding would cause, as well as the expense to the state and the diversion of mental health resources from other patients to question the presumption of competence, particularly where the patient is clearly in need of treatment.

This decision causes considerable consternation in the mental health system for a variety of reasons. Chief among these are whether the mental health system will require universal administrative proceedings for voluntary patients, whether facility personnel have a constitutional peril added to other disincentives to treatment of seriously mentally ill persons, and what effect this has on state laws requiring voluntary admission where it is appropriate. 90 For advocates of persons in need of psychiatric treatment, the disincentives this decision creates in accepting patients who need treatment are considerable.

In contrast, the Court has refused to increase the level of difficulty in obtaining treatment in cases of the commitment of children of minor age, 91 and has not intervened in the question of whether a state could use different standards of proof for different disabilities. 92 Yet the Court persists in its suspicion of psychiatry due to a "wide divergence of opinion and diagnoses" 93 and its premise that these decisions are inherently a "massive curtailment of liberty." 94 This language has been used repeatedly by courts in the context of judicially ordered institutionalization. The question should be asked whether, in the modern era

89. Id.
94. Humphrey v. Cady, 405 U.S. 504, 509 (1972); O'Connor, 422 U.S. at 595.
of limited psychiatric resources for the severely mentally ill, is this concept still accurate or credible?

Today, there are very few incentives to prolong expensive treatment, as evidenced by the contemporary issues of limiting government spending by using a managed care system. Length of hospital stays and reduction in the use of civil commitment all attest to a low likelihood of excessive treatment.\(^9\) Also, given the strong propensity of the state to treat patients in the community and to use standard approved psychiatric medications, can it really be said that this is a massive deprivation of freedom? All of these new programs are clearly aimed at avoiding institutionalization and promoting a greater freedom through treatment.\(^9\) Finally, what could be the measure of damages for a patient who was undoubtedly better off being served sooner, perhaps even while living, by virtue of professionally appropriate intervention as in the case of Zinermon v. Burch.

The patient has a strong interest in avoiding a delay in treatment. This is not necessarily the interest of the court or the patient advocate, who see their role as zealously resisting the proposal for treatment.\(^9\) As with most serious illness, delay can make recovery or amelioration disproportionately more difficult and in some cases impossible.\(^9\) The understanding or rationality element of competence would fundamentally require that a patient be objectively aware of the mental illness. Because denial of existing psychopathology strongly suggests incom-

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96. Indeed, tort damages have been awarded for the liberty denied by a failure to treat a patient in a timely way. See Whitetree v. State of New York, 290 N.Y.S.2d 486 (1968).


petence, a patient who rejects a physician’s diagnosis that to a reason-
able medical certainty a mental illness exists and needs to be treated,
would fundamentally fail to satisfy this criterion.99 For example, a pa-
tient who actually realizes a terminal illness, but refuses to have it
treated does not necessarily mean he is incompetent.100 A competent
person would at least need to realize that he was entering a hospital for
treatment and that release might not be immediately available upon his
request.101 This can be called a rational relationship test. A patient, in
order to be able to make a decision, must be able to recognize basic
facts that are relevant to the reality of his or her situation and be able
to make a decision in his or her personal best interest. Beyond the pa-
tient’s realization of the relevancy of facts, there is the further issue of
his or her ability to assess them. As an example, a patient may not be
able to understand that modern psychotropic medications have rela-
tively few side effects and instances of permanent negative health con-
sequences, especially when these are balanced against the patient’s
need for them to function or remain away from dangers.102

These deficits in decision-making correlate to certain types of men-
tal illness. For example, patients hospitalized with a diagnosis of
schizophrenia or depression more often show deficits in their decision
making than hospitalized medically ill patients or non-patients.
Schizophrenic patients tend to be more impaired than depressed pa-
tients and patients with more severe schizophrenia, especially those
with thought disturbances, who have more manifest deficits in under-
standing and reasoning.103 There is empirical evidence that a patient’s
ability to understand and rationally appreciate facts of the diagnosed
illness indicates decision-making competency, especially of patients
with schizophrenia.104 Patients unaware that they are sick cannot ade-

99. See Berg, supra note 54, at 355, 366.
100. See In re O’Connor, 72 N.Y.2d 517, 528 (1988).
101. See Zinermon, 494 U.S. at 379, 380 and n.99 (discussing the Ameri-
can Psychiatric Association Task Force on Consent to Voluntary Hospitaliza-
tion).
102. William M. Glazer and John M. Kane, Depot Neuroleptic Therapy: An
Underutilized Treatment Option, 53 J. CLINICAL PSYCHIATRY 426, 431-32
103. J.W. Berg et al., Constructing Competence: Formulating Standards of
Legal Competence to Make Medical Decisions, 48 RUTGERS L. REV. 345, 372-
74, n.94 (1996).
104. Id. at 381, 382, n. 106.
quately weigh the risk or benefits of potential treatments. There is also the natural concurrence of the physician and patient in treatment situations, i.e., where a patient accepts sound medical judgments made under the standards of the profession as indicative of the appropriateness of treatment and sound judgment of the patient. Whereas rejection of clearly necessary treatment, e.g., in the case of a life-threatening condition and a patient’s suicidal tendency, might call for an assessment of competency. This is, of course, not to say that disagreement with clinicians is evidence of incompetence. Rather, in appropriate and substantial deviations from normal patient behavior, it would naturally raise a need to consider whether further investigation is warranted.

The law’s recognition of the importance of personal autonomy in competency determinations is evident in requiring “clear and convincing” evidence before autonomy is reduced or negated. Judicial decisions have formulated the legal criteria for involuntary treatment without much apparent concern for the deliterious effects they have had on rendering treatment, for costs of litigation and treatment, or for delay in patient amelioration. It is one thing to utilize a high burden of proof when taking autonomy from a patient. It becomes a questionable calculus both for the state and the patient to use the same high standard for giving the patient necessary and expensive psychiatric treatment, which is deemed necessary by a court or by a physician, is within acceptable medical standards, and whose ultimate purpose is to restore autonomy.

The risk of a given drug approved by the United States Food and Drug Administration are certainly less than the risks of remaining untreated and not being restored to health, autonomy, and to a quality life. Additionally, untreated severe mental illness increases the

105. See Steven K. Hoge et al., A Prospective, Multicenter Study of Patient’s Refusal of Antipsychotic Medication, 47 ARCHIVES GEN. PSYCHIATRY 949 (1990)

106. Parham, 442 U.S. 584 (1979) (holding that a minor-aged child does not have a right to an independent judicial commitment hearing where parents consent for his treatment, as long as physician concurrence is consistent with professional standards).


108. See Addington, 441 U.S. at 432-33.
chances of suicide and death from other causes, above that of for ei-
ther non-mentally ill persons or for persons treated for mental illness;
one by suicide, the other by homicide.  

In consequentialist terms, the issue is whether the harm of incor-
correctly labeling autonomous agents as incompetent is outweighed
by the harm of incorrectly ignoring the patient’s autonomy, or right of
self-determination. The latter is significant to the extent the patient’s
well-being is at risk; no harm results from allowing an incompetent
patient to make a decision of minimal effect or one that is in keeping
with his or her objective best interests. Accordingly, only competent
patients should be free to make decisions that are not in their best in-
terests while others could be erroneously permitted to do so at their
peril.

The confusion in attempting to expand due process standards
reached an surrealistic heights when the highest court in New York
State stretched the “clear and convincing” evidentiary standard indis-
criminately beyond the issue of patient competency and reviewed the
actual clinical standards of treatment. In Rivers v. Katz, the Court of
Appeals held that:

The State would bear the burden of demonstrating by
clear and convincing evidence the patient’s incapacity
to make a treatment decision . . . [I]f, however, the
court concludes that the patient lacks the capacity to
determine the course of his own treatment, the court
must determine whether the proposed treatment is nar-
rowly tailored to give substantive effect to the patient’s
liberty interest . . . [t]he State would bear the burden to
establish by clear and convincing evidence that the
proposed treatment meets these criteria.

Here, the court redundantly adjudicates the need of treatment by
standard psychotropic medication for a patient who already was adju-
dicated incompetent and found to be in need of psychiatric treatment.
Many other state courts have similarly injected the judicial process

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112. Id. at 497-98. In footnote 7, the court impliedly suggests that lower
courts make findings of facts involving clinical psychiatric diagnosis and app-
llicable treatments calling upon the trial judge to perform peer review of phy-
sicians. Id.
into the psychiatric treatment system.\textsuperscript{113} Rivers, and much of the judicial intervention, suggests a redundancy to the state’s involuntary treatment process. The delays and expense should be of much concern to a mentally ill patient as well as to government and society. They should also be of concern to advocates of effective treatment.\textsuperscript{114}

Rivers typifies how courts have promoted neither state or patient interest to improve the availability or the quality of mental health treatment. Rivers demonstrates an appalling misunderstanding of psychiatry. The Court said at the very least that the patient’s competence or incompetence to make the treatment decision is “uniquely a judicial, not a medical function.”\textsuperscript{115} In fact, patients, if treated early in their mental disease, can return home in a few weeks. “Paradoxically, if the patient’s right to refuse medication is protected exclusively by judicial process, the patients will never make the decision themselves, the le-

\begin{itemize}
\item \textsuperscript{114} While judicial mechanisms provide a significant degree of protection for individual rights, they also entail a number of disadvantages, including high cost and substantial delay.” Berg, supra note 54, at 393.
\end{itemize}
gal process will make the decision for them.\textsuperscript{116} Thus, the practical effect of \textit{Rivers} hearings has been not only without much benefit to anyone, but worse, diminished necessary treatment for most in need. Courts ratify the physicians' decision in more than ninety percent of cases, meanwhile the patient languishes in theoretical "liberty" within the four walls of an institution. Previously, the resolution of patient objections by administrative adjudication took ten to twenty-one days. After the \textit{Rivers} ruling on whether it is legal to treat over that objection, it took thirty-one to sixty-eight days. This causes an enormous expense in hospital staff salaries, legal resources (which are not as available to private, state-licensed clinics), and a deprivation of patient liberty, in addition to prolonged hospital stays.\textsuperscript{117}

The root of the matter is that judicial decisions concerning competence are expensive and slow. Such a process for mental health is not well suited for judicial review.\textsuperscript{118}

\begin{itemize}
\item \textsuperscript{116} See Brakel & Davis, \textit{supra} note 115, at 450. Competence determinations, known as clinical competency, are made by the thousands every day by physicians and hospitals. And, indeed, even in a court of law, it is not the court which decides competency, but rather selects from among expert witnesses' determinations.
\item \textsuperscript{117} See J. Richard Ciccone et al., \textit{Medication Refusal and Judicial Activism: A Reexamination of the Effects of the Rivers Decision}, \textit{44 Hosp. & Comm. Psychiatry} 555, 560 (1993). "Excluding the court costs, the price of the patient's refusals in extra institutional care and legal fees was $13,000 for the first and $19,000 for the second patient. None of this, of course, takes into account the 'hidden' costs of managing a deteriorating patient and the attendant effects on the safety and quality of care within the institution generally." Brakel & Davis, \textit{supra} note 115, at 460.
\item \textsuperscript{118} See Williams et al., \textit{Drug Treatment Refusal and Length of Hospitalization of Insanity Acquittees}, \textit{16 Bull. Am. Acad. Psychiatry & L.} 279 (1988) (treatment over objection sustained in 97% of cases initially and 100% after a second opinion); Hargraves et al., \textit{Effects of the Jamison-Farabee Consent Decree: Due Process Protection for Involuntary Psychiatric Patients Treated with Psychoactive Drugs}, \textit{144 Am. J. Psychiatry} 188, 188 (1987) (98% judicial approval); "In total, there have been approximately twelve studies of 5,000 cases of patient's refusals of treatment. Courts have sustained the refusals in only three percent of the cases, at an average time cost of forty-eight days. Clinical review has affirmed the patient's rejection of the treatment in four percent of the cases and comes at a cost of three to fifteen days in treatment time lost. . . . even in those rare cases when the formal judicial or clinical decision upholds the patient's right to refuse, clinical deterioration often results." \textit{Id. See also} Brakel & Davis, \textit{supra} note 115, at 456 (1991).
\end{itemize}
gendered legal issue in some cases, treatment decisions rarely do. Courts, however, routinely get involved with treatment decisions by virtue of competency issues. These decisions have consequences in terms of suffering, delayed recovery, restoration of health and substantial economic costs to everyone involved. There also exists a serious question of the practical effect judicial review has on clinical recommendations to administer anti-psychotic medications. The usual result is ratification of the clinical decision to treat over a patient’s objection, often times without the patient ever seeing a judge. One result of such a hearing is the tendency to delay relief of the patient’s suffering while decreasing the quality of care that to the patient. In addition, these hearings tax the limited resources of the mental health system by requiring attendance by psychiatrists and other professionals, such as facility staff and state attorneys. In fact, patients that withdrew their application for court review before any proceedings began actually had shorter hospitalizations. Although, court review of medication decisions, such as required by the Rivers decision, are intended to reduce medication errors and support the patient’s right to autonomy through informed consent. The results are largely illusory, if not contradictory. There is evidence that such court reviews tend to cause greater care at the clinical level, but “[i]f this remains the sole justification for a [court’s] review procedure, [] perhaps a more economical approach should be devised.”

Mental health litigation is not particularly welcome by many judges due to its complexities and uncertainties. Furthermore, there is evi-

119. See J. Richard Ciccone et al., supra note 117, at 556.
121. See Moynihan, supra note 65, at 560.
122. Hargraves, et al., supra note 118, at 190.
123. Judicial decisions have become increasingly bizarre as judges make diagnoses, order and reject treatments, and discharge patients. The courts often manifest gross ignorance of the issue about which they create laws, relying on lawyers and doctors who pose as experts but are actually persuaders, advocates, and propagandists with economic or other agendas. In addition, the jury system is not conducive to an accurate evaluation of care.

vidence that judicial misunderstanding of psychiatry ultimately denies the state authority to act parens patriae, while concomitantly denying a person with mental illness expeditious amelioration of their condition. The dissenting opinion in Washington v. Harper evinces a particularly strong suspicion of American psychiatry. This dissent strongly implies that in American psychiatry there is the same potential for blatant abuse of civil rights as seen in the former Soviet Union. Such an attitude reflects a prevalent judicial overestimation of the dangers of drug therapy, despite some legitimate concerns about the carelessness and mistakes that often occur for a variety of reasons in institutional settings. It is not necessary in this controversy to embrace either extreme, where the system is totally supervised by the judiciary or where there is no need for independent judicial review.

Perhaps adding even more confusion is the fact that lawyers retained to represent patients have generally taken the attitude that even in cases where their client is incompetent, they must resist the offer of treatment. In many instances, this attitude unnecessarily increases expense and delay or denial of treatment based on a rote legal posturing that is more suited for criminal defense than for medical intervention.

124. See Brakel & Davis, supra note 115, at 343.
125. See Washington v. Harper, 494 U.S. 210, 237 (1990) (Justices Stevens, Brennan and Marshall dissenting). Other judicial opinion have expressed similar views that, although psychiatric medications were not used for "punishing thought," they were used as a means to "controlling thoughts... or by coercing acceptance of particular thoughts and beliefs." Davis v. Hubbard, 506 F. Supp. 915, 926-33 (1980). Of course, it is absolutely improper to attempt to coerce all patients to join the Republican or Democratic party, or in the case of the Soviet Union, to compel a patient to agree with the political views of the state. It is quite another to hope that the medications change the patient's view of reality that beforehand has them believing that squirrels are talking to them, or that God has given them a mandate to kill. Studies have shown that antipsychotic drugs can correct thought aberrations and return perception, thinking, and speech to what would be called normal. See Hurt, Holzman & Davis, Thought Disorder: The Measurement of Its Changes, 40 Arch. Gen. Psychiatry 1281 (1983).
128. For example, drug therapy studies confirm that there is a definite
Contemporary commitment laws are overexacting and leave many individuals without the effective care needed. Courts appear to have no particular expertise in evaluating the patients in these cases, causing a dilemma with a limited review on appeal when a trial court may have misdiagnosed the patients. Furthermore, such laws cripple a limited-resource system by compelling participation, rather ineffectively, in a legal contest rather than a curative. Because of this regime, patients can be forced to wait for weeks or months for a court hearing with no effective treatment.

From the patients' point of view, the last two centuries of institutional treatment have fostered a constant struggle to be afforded fundamental human rights. Until fairly recently, patient consent to treatment and protection against abuse or arbitrary confinement were not high priorities in either the United States or England. In these two nations, the governments' attention to the rights of patients with mental illness lagged behind the need to establish a treatment system. Patient rights were gradually recognized in two distinct scenarios: whenever there were new medical discoveries that enabled individuals to enjoy greater freedom, or when governmental reforms responded to a procession of horrible scandals. It took these scandals that shocked the public conscience to create committees of visiting professionals and citizens to inspect facilities for the mentally ill. These were called the lunacy commissions.

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positive relationship between an amount of a medication (“therapeutic dosage”) and the beneficial effects. If a treating psychiatrist feels compelled to administer a lower dosage due to the vagaries of judicially constructed “least restrictive” requirement, this might inhibit speedy amelioration from unrestricted treatment. See Brakel & Davis, supra note 115, at 453 n.65.


The end of the millennia brings with it the fifth decade after having ended the primacy of the large mental health institution, in one of the most significant, government sponsored social movements in late twentieth century American history, commonly termed "de-institutionalization." This policy has meant freedom from the institutional treatment settings that were, in some cases, like prisons fraught with discomforts and dangers. Of course, the community treatment and support systems, to ensure that patients maintained their therapeutic regimens, were also necessary; but unfortunately were not developed in a coordinated fashion with the closing of the institutions and the discharge of patients.

This change has created IMI patients who can function normally in the community as long as they are able to maintain therapeutic levels of medications and receive remedial measures when therapeutic conditions fail. The problem with the current system is that without the constant supervision formerly provided by the institution, patients often stop taking their medications and mentally decompensate, thereby needing more intensive care. Compounding this problem of an expeditious return to normalcy and community living, during the last three decades courts have imposed an intense level of adversarial due process on psychiatric treatment for individuals deemed incompetent to appointment of the Lunacy Commission of 1815, and its limited legislative precursor, the Madhouse Act of 1774, began the English tradition of governmental supervision for care of the mentally ill. An example of this evolution in the United States was the Utica-Marcy Act of 1842. This law created the State Lunacy Commission that would later become a state agency and then a constitutionally established department of state government, the New York State Department of Mental Hygiene, pursuant to the state constitutional reforms of Governor Al Smith. See David B. Schwartz, *Quality Assurance in the Asylum, Quality of Care Newsletter* 6 (June 1983); "The Department of Mental Hygiene, as distinguished from the institutions under its control is a lineal descendant of the Lunacy Commission established by law in 1889. . . . In 1912, the Lunacy Commission became the State Hospital Commission . . . and in 1927 the Department of Mental Hygiene was organized under a single Commissioner to whom was granted all the power previously exercised by the Commission." The Care of the Mentally Ill in New York, *supra* note 65, at 12.

This term was coined to describe the closing of the large institutional mental hospitals beginning in the 1950s. See Moynihan, *supra* note 61, at 19.

133. *See* ANN BRADEN JOHNSON, OUT OF BEDLAM 70 (1990); *see also* DAVID A. ROCHEFORT, FROM POORHOUSES TO HOMELESSNESS: POLICY ANALYSIS AND MENTAL HEALTH CARE 228 (1993).
participate in their treatment. In the absence of a plan for future treat-
ment of a patient, the current system converts to a crypto-criminal
model that does little more than stigmatizes a patient as “dangerous”
and assigns a lawyer to be an adversary to all treatment while awaiting
a congested court to hear the case. The mental stability necessary to
live autonomously would be furthered if the patient had a plan, in the
form of a Nexum, a mental health advance directive, to resume his
medication and treatment, without having to obtain judicial permis-
sion.

IV. UTILITY OF THE ADVANCE DIRECTIVE

In Homeric legend, the Odyssey captures the essence of self-
determination. In one of his many adventures as the cunning Odysseus
(later called Ulysses by the Romans) devised a method to ensure his
survival. Although he wanted to listen to the sweet, but highly dan-
gerous, songs of the Sirens, he knew that those who dared to listen in-
evitably lost all rational control over their judgment and succumbed to
the Sirens’ seductive invitation to approach closer. Those who ap-
proached faced certain death by crashing onto the shoals. Odysseus in-
stucted his crew to tie him to the ship’s mast and not release him, no
matter what he said or ordered them to do. Odysseus also instructed
the crew to put wax in their own ears to avoid hearing the Sirens.
Odysseus’ authority and foresight to issue an order, in advance to his
crew, enhanced his own well-being for the time when he knew he
would lose control of his right mind. Temporarily delegating his
autonomy preserved Odysseus’ life and his ultimate authority to com-
mand the ship while allowing him to experience something unsur-
passed. Was Odysseus’ power diminished or enhanced? Avoiding a
known or likely encounter with death cannot be deemed an unreason-
able bargain, especially when the return was one of the greatest ad-
ventures of the Odyssey.¹³⁴

¹³⁴ [Circe] warned [Odysseus] that he must next pass the Island
of the Sirens, whose beautiful voices enchanted all who sail near.
Now, they sat and sang in a meadows among the heaped bones of
sailors whom they had drawn to their death. “Plug your men’s
ears with bees-wax,” advised Circe, “and if you are eager to hear
their music, have your crew bind you hand and foot to the mast,
and make them swear not to let you escape, however harshly you
may threaten them.” As the ship approached Siren Land, Odysseus
took Circe’s advice, and the Sirens sang so sweetly, promising him
foreknowledge of all future happenings on earth, that he shouted
In ancient Roman Law the Nexum became the first form of contract. Its great significance was that it marked a transition from law based on status imposed by social or political hierarchy, to one empowering individuals through voluntary relationships to define and choose mutual rights enforceable by civil law. Nexum formed the bond that legally linked relationships, albeit at first mostly one of an economic variety. Nevertheless, it "cannot be doubted that [the Nexum] constituted the stage in the history of Contract-law from which all modern conceptions of contract took their start." 135

Although the concept of state protection of autonomy was a feature of Greek philosophy and culture, this marked the beginning of its manifestation and availability to the general citizenry. Initially based on economic principles, over time, the Nexum extended to all aspects of appropriate relationships and agreements. By emulating the example of Odysseus and following the format of the Nexum, a new form of agreement would be created. It enhances the unilateral testamentary "living will" to a bilateral contract, permitting a patient to give advanced medical consent and solidifying a therapeutic alliance between the patient and health care provider.

It is national policy to encourage and enhance patient autonomy by means of advance directives. 136 An advance directive is a contingent

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set of instructions in the event a person's judgment becomes so impaired that they are not able to function for themselves. Advance directive statutes for general health care exist in all fifty states and numerous territories. Since most of these statutes "permit revocation of the living will by act or statement regardless of the drafter's mental or physical condition," they are inappropriate for most cases of intermittently mental illness. This is why twelve states have advance directives that address the special circumstances of mental illness where all laws proscribe revocation where a person is incompetent.\textsuperscript{138}

Promoting the use of advance directives is a matter of federal health care policy pursuant to the Patient Self-Determination Act.\textsuperscript{139} The purpose of this law is to enhance patient autonomy and reduce unnecessary delay and expense in rendering health care.\textsuperscript{140} The right of an individual to control health care for the body and mind during periods of

\begin{itemize}
\item \textsuperscript{137} Roberto Cuca, Note, \textit{Ulysses in Minnesota: First Steps Toward A Self-Binding Psychiatric Advance Directive Statute}, 78 CORNELL L. REV. 1152, 1158 (1993). "This reflects the belief that it is better to err against patient's wishes by continuing, rather than withdrawing, life-sustaining treatment." \textit{Id.}
\item But, in the case of a person who mentally deteriorates to the point of incompetence and risks reinstitutionalization, the effect is the opposite from continuing treatment. New York State's advance directive statute is a good example of the inappropriateness of a general health instrument for mental health care. Under its terms and interpretation, the advance directive becomes void upon simple revocation or objection from an incompetent patient because of a strong presumption of competency that cannot be ignored by a court order. Of course, for the majority of patients with severe mental illness, there is an unawareness and denial of their own illness and revocation of the advance directive. Obviously, this contradicts the very purpose for having an advance directive, namely to spring into effect and expeditiously render treatment when mental illness is severe enough to debilitate a patient's decision-making. \textit{See N.Y. PUB. HEALTH LAW, § 2985.}
\item \textsuperscript{138} Twelve states have specialized advance directive statutes for persons with mental illness: Alaska, Hawaii, Idaho, Illinois, Maine, Minnesota, North Carolina, Oklahoma, Oregon, South Dakota, Texas and Utah. \textit{See} Chart A for a comparison of the principle characteristics of these statutes.
\item \textsuperscript{139} \textit{See} 42 U.S.C. § 1395cc(f)(3) ("An adult or emancipated minor may give an individual instruction . . . to take effect only if a specific condition arises.").
\item \textsuperscript{140} "The truth is that 'autonomy' originated from Kant, and that it was Kant who called attention to the concept." \textit{Giovanni Sartori, Democratic Theory} 299 (1967).
\end{itemize}
inability to make competent decisions, is an important extension of an ancient right of autonomy. In philosophical terms, it is the exercise of personal free will. Legal competency is the hinge of the law that separates a government’s obligation from protecting an individual’s decision to one protecting the individual from his decision. Consent is not only the prime mover in personal choice on fundamental matters, but it is also the “sheet anchor” of democracy itself.

The state has a traditionally strong interest in encouraging patients to make decisions when they are competent. Consent means the “exercise of sufficient mental capacity to make an intelligent choice to do something proposed by another. It supposes a physical power of acting and free use of those powers.” Health care autonomy intrinsically requires that the patient be offered a primary role in the prescription of care, however, this role may be limited by law, professional medical standards, and ethics.


142. See Glass, supra note 20, at 5.

143. See LINCOLN ON DEMOCRACY 71 (Mario M. Cuomo & Harold Holzer eds. 1990).

What I do say is, that no man is good enough to govern another man, without that other’s consent. I say this is the leading principle—the sheet anchor of American republicanism. Our Declaration of Independence says: That to secure these rights, governments are instituted among men, deriving their just powers from the consent of the governed.

Id.

144. BLACK’S LAW DICTIONARY 305 (6th Ed. 1990).

145. See Jessica Wilen Berg et al., Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions, 48 RUTGERS L.
In the history of Western law, especially from the Enlightenment to the present, the invocation of these legal rights and privileges turns upon the determination of a person's competence. This level of competence is determined by a court, or someone recognized by law as able or obliged to do so. In mental health care today, the determination of legal competency is probably the "central issue in bioethics." The issue is synonymous with the struggle for personal autonomy, particularly with the revolutionary changes in mental health care from the constrictions of the large asylums to the freedoms of outpatient care in the community.

The determination of legal competence is a recognition that an individual may or may not exercise certain legal rights. The law presumes adults are competent, for without this presumption, making competency decisions for every significant decision a patient makes would be impossible and absurd. The law's determination of a person's incompetency is seldom tied to a particular mental or physical condition per se. Rather, the determination is defined functionally. It can be applied to any condition or circumstance that significantly disables a person's mental processes of thought and rational decision-making. However, competency may vary with the factual situation, the legal jurisdiction and the particular culture. A common example of this type is medical consent, given a special name of "informed consent." "Informed consent" requires the treating physician to impart or explain the medical procedure in layman's terms (the "reasonable prudent patient" standard) so that the medical decision, with its risk and benefits, is adequately understood. Only with an adequate explanation of this relevant information in the context of "informed consent" can a patient competently decide to consent or refuse the recommended course of complex medical treatment.

Rev. 345, 346 (1996); see also Paul S. Appelbaum et al., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 21-26 (1987).

146. Fennel, supra note 131, at 1-2.


148. See Glass, supra note 20, at 5, 6.


Another example is the law pertaining to sexual consent, where a bright demarcation line exists between legal and illegal acts, even when it is difficult to determine the facts surrounding consent. It is instructive that children below a certain age are considered *per se* unable to give consent, despite their subjective abilities. Yet, even this objectively bright line has become fuzzy in contemporary times. In certain situations covering sexual rights, competency for medical and mental health care is granted to children.¹⁵¹ For example, there is also a strong movement to grant broader sexual rights to persons with mental retardation. A person with mental retardation may be legally competent to make certain decisions about engaging in sexual behavior of a simpler nature, such as sexual petting, while simultaneously not be competent to engage in sexual intercourse.¹⁵²

Competency for sexual consent can vary with the particular jurisdiction,¹⁵³ especially with the culture changes over the centuries.¹⁵⁴ Thus, to some extent, the legal definition of competency reflects the legal establishment, traditions and customs of the courts, the legislature and contemporary culture. To that extent, in marginal cases, these group values will trump or circumscribe some autonomy of the individual.¹⁵⁵ Other examples of situational competency could be hypothesized in terms of different medical treatments that vary greatly in terms of their complexity, difficulty of comprehension, and their attendant risks of further debility or death versus the expected benefits.¹⁵⁶ Receiving professional advice or help usually increases or enhances a person's ability to make these decisions. In questionable

cases, this advice can make the difference between being found competent, retaining the right of self-determination, or submission to the inadequately responsive judicial process.

The law does not grant an individual the right to be so mentally ill that the manifestations of the disease cause actions that might be offensive to public sensibilities or are likely to result in more serious anti-social acts.\(^1\) Both in its police and parens patriae power, the state may use reasonable means to protect those whose ability to make decisions is impaired while restoring that decision-making to a competent level. In fact the state imposes a general duty on itself and its citizens to behave rationally in their decision-making. There is no more ubiquitous legal standard than that of "reasonableness." Reasonableness is the heart of civil law, and defines the minimal level of behavior for government under the Equal Protection clause of the Fourteenth Amendment.\(^2\) Justice Benjamin A. Cardozo best expressed the need to possess a sound, reasoning mind in order to make personal health care decisions in \textit{Schloendorff v. Society of N.Y. Hosp.}\(^3\)

Every human being of adult years and sound mind has a right to determine what should be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages . . . This is true, except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained.\(^4\)

The synthesis of this personal liberty carries with it some obligation to make healthful decisions. "Under ancient Greek law (from which medical ethics and practices descended) physicians not only had a duty to treat those with illnesses, but citizens had an equal duty to accept that treatment, in order to maximize their functioning in society."\(^5\) The state has a strong interest in a rational citizenry and in minimizing the effects of mental illness. However, the state must re-

\(^1\) See supra note 37; see also RAEL JEAN ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS 256-61 (1990).
\(^3\) 105 N.E. 92 (N.Y. 1914).
\(^4\) Id. at 93; People v. Medina, 705 P. 2d 961, 968 (Colo. 1985).
member that hospitalization of a patient without effective treatment is arguably a form of preventive detention, or possibly a tort. Patients who refuse treatment have more reports of violence on others with whom they are hospitalized, require significantly higher costs, take a disproportionately high amount of mental health resources, and result in longer hospital stays and increased incidence of homelessness. These interests can be united through an integrated, state-sponsored Nexum; but only if the state can legally use incentives and other means to encourage its use by patients who routinely receive services from the mental health system.

Other state interests include providing adequate due process, cost-efficient services, and confirmation that the services, including any judicial proceedings, are therapeutically effective. In appropriate circumstances, these state interests may transcend the individual’s preference at the time an advance directive takes effect. However, there is no particular constitutional requirement that competency to consent or refuse psychiatric treatment be litigated in a court of law, especially for standard medications that have been approved for use by the Food and Drug Administration and are routinely prescribed for particular illnesses.

Determination of a patient’s decision-making competency should conform to law based on medical practice and generally accepted

163. See TORREY, supra note 2, at 43-60.
164. See Shelly Levin et al., A Controlled Comparison of Involuntarily Hospitalized Medication Refusers and Acceptors, 19 BULL. AM. ACAD. PSY. & L. 161, 169 (1991). Although this study failed to find any difference in lengths of hospital stay between refusers and accepters of psychiatric medication, others have also found “that refusers have significantly less insight into their illness, less awareness of the rationale for their treatment, and less confidence in the abilities of the ward staff . . . [and they] are significantly more likely to be restrained than accepters.” Paul S. Appelbaum & Steven K. Hoge, The Right to Refuse Treatment: What the Research Reveals, 4 BEH. SCI. & L. 279, 286 (1986).
medical judgment. Common sense and experienced, physicians should defer to a patient's choice, giving it widest berth when a choice is consistent with good practice, restoration of health and functioning, reduction of suffering, and reasonable economic efficiency. Conversely, a patient's competency should be questioned when a decision to refuse medical treatment does not conform to the medical condition and patient circumstances. This has been termed a "sliding scale" of competency, "therapeutic jurisprudence" or an "important distinction between assent and objection." The important aspect of this approach is that it permits the patient maximum autonomy in decision-making, even when mental illness puts one's decision-making capabilities in the marginal or doubtful range. \footnote{168}{See Bruce J. Winick, \textit{Competency to Consent to Treatment: The Distinction Between Assent and Objection}, 28 Hous. L. Rev. 15, 21 (1991).}

This would also make the design of the Nexum more effective because it would conform with traditional contractual principles. Courts generally judge the "reasonableness" of contracts, rather than evaluate the competency of the contracting parties. Competence to participate in a Nexum would be required at the time of execution. This can be easily performed by a physician, or other legally qualified person under statute or case law to make a clinical judgment of decision-making competence. As found in contract law, the Nexum could be terminated when the principal again attains mental competence. \footnote{169}{See Bruce J. Winick, \textit{On Autonomy: Legal and Psychological Perspectives}, 37 Vill. L. Rev. 1705, 1775 (1992).} This would be consistent with presumptions about adult competency and deference to both personal choice and clinical judgment, while also consistent with state's interest under its \textit{parens patriae} power that the injury to autonomy values produced by interference with individual self-determination should be tolerated only to prevent the greater injury to the individual's welfare that would occur by allowing incompetents to make such decisions. We should hesitate to interfere with a patient's assent to a treatment recommended by his physician since the physician's recommendation ordinarily provides stronger evidence that the patient's choice, rather than being injurious to his welfare, will further it. In contrast, an objection to recommended treatment may provide greater justification
for conducting an inquiry into competency.\textsuperscript{170}

This should be viewed as beneficial persuasion, not as undue coercion. Research shows that denial of mental illness is the most common reason for refusal of clinically appropriate treatment.\textsuperscript{171} As Chief Justice Burger expressed, “one who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty or free of stigma.”\textsuperscript{172}

The law can legitimately give a greater measure of deference to the proactive treatment side involving marginal questions of patient competency. Otherwise, the law plays into the rejection of treatment and lack of awareness symptomology of some mental illness by providing supports, such as a paid advocate, for the patient’s erroneous view of reality and his or her best interest.\textsuperscript{173} We no longer live in an era where state policy is to repopulate its institutions; quite the opposite, states are eager to close them forever. There is no longer an abundance of financial resources for either health or mental health care. The federal and state governments are desperately searching for ways to avoid rendering expensive care, and the new era of “managed care,” for both health and mental health treatment is primarily focused on this approach.\textsuperscript{174} From this perspective, based upon maximizing reimbursement from public monies or insurance gets intensified due to these funding squeezes or incentives. This makes the rendering of care for a person with intermittent mental illness more difficult because there are fewer resources to deal with judicial processes to validate a person’s treatment requirements.\textsuperscript{175} For many of the intermittently mentally ill

\begin{footnotesize}
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\item \textsuperscript{170} Winick, supra note 168, at 43-44.
\item \textsuperscript{172} Addington, 441 U.S. at 429 (1979).
\item \textsuperscript{173} There is increasing evidence suggesting that treatment refusals among the seriously mentally ill are symptomatic of the disease. See Ciccone et al., Right to Refuse Treatment: Impact of Rivers v. Katz, 18 BULL. AM. ACAD. PSY. & L. 203, 204 (1990); see also Bloom et al., An Empirical View of Patients Exercising Their Right to Refuse Treatment, 7 INTL. J. L. PSYCHIATRY 315 (1984).
\item \textsuperscript{174} See John Petrila, Ethics, Money, and the Problem of Coercion in Managed Behavioral Health Care, 40 ST. LOUIS U. L. J. 359, 368-77 (1996).
\item \textsuperscript{175} Leonard S. Rubenstein, Ending Discrimination Against Mental Health
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\end{footnotesize}
managed care plans will be planned denial of care.

Legal adjudication has become so mired in adversarial procedures and politics that paradoxically rendering effective treatment is threatened.\textsuperscript{176} Limits can be placed on patient’s treatment choices. A patient’s desire to be treated, or to refuse treatment, can be limited by other governmental or profession interests as with cases of unapproved “experimental” drugs, human subject research, when a patient’s refusal is a pretext for an attempt at suicide, or when professional ethics forbid treatments.\textsuperscript{177} When a person becomes mentally incompetent, it is legally and clinically equivalent to being comatose because there is


For generations, mental health advocates have bitterly complained that health plans of every kind discriminate in their coverage of mental health conditions. Compared to physical health care, mental health care has been subjected to stricter limits on utilization, higher co-payments, lower benefits caps and more restricted types of offered services. For people with more severe mental illnesses, such as schizophrenia, access to appropriate services such as psychiatric rehabilitation is even more problematic, and the level of unmet need is truly staggering. These unmet needs result not only in individual suffering and increased use of involuntary interventions, but also in social consequences like homelessness and increased levels of addiction.

\textit{Id.}


In no field of law is the divisive, dualistic character of America’s legal system more apparent than in the field known as mental disability law. There, legislatures, courts, and scholarly tradition have combined to produce an unwieldy amalgam of general principles and particularized provisions so riddled with internal conflict as to justify a diagnosis of florid legal schizophrenia. In this field of law, the state’s \textit{parens patriae} competes with its police power; the patient’s right to treatment coexists (all so uneasily) with the right to refuse it; the therapist’s obligation to preserve client confidentiality militates against the duty to warn others; the psychiatrist’s wish to treat is undercut by legal compulsion to deinstitutionalize or to refrain from institutionalization altogether; while the pressure on the provider/administrator toward early release increases the risk of legal liability; and the doctrine to deliver least restrictive treatment threatens the disabled with the reality of being subjected to a regimen that retains most of the coercion and restraints of the institutional setting, but without the treatment, or worse, of being left with the unfettered freedom to deteriorate and die in the streets.

\textit{Id.}

no treatment decision upon which a physician, hospital, or other provider can reliably act. In defining this incapacitated state, the law has traditionally used the term "incompetent." 178 The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research summed up the problems of judicial review of medical determinations.

Furthermore, resorting to the courts to adjudicate incompetency— that is, to confirm the patient's lack of decisional capacity— is often so burdensome to both providers and patients or to their families that there is a tremendous reluctance to undertake it. Even when an adjudication of incompetency is sought, the proceedings are in many cases so perfunctory and/or deferential to the professional expertise of providers that the role of the courts amounts to little more than pro forma ratification of what was already apparent to health professionals. Frequently . . . it appears that the process of judicial review is merely a formality. Judges may not feel that they are able to add very much to the decision already reached by those most intimately involved, particularly in cases that are brought simply to obtain judicial sanction for an agreed course of conduct. 179

Patient self-management is widely accepted today as the preferred method of treatment, i.e., a self-guardianship. Patients can be educated as to the onset of their condition, as well as what has been successful treating them in the past. 180 The IMI patient can be given the supplemental supervision needed to decide on the type and dose of drugs that will best help, and to execute a Nexum in the event that they need assisted outpatient treatment. 181 Congress has also spoken clearly in favor of promoting the use of advance directives through the Patient Self-Determination Act (PSDA).

The goals and concerns [of the Act] can be conceptualized in terms of process values and outcome preferences. The goal of empowerment and the concerns about patient anxiety, comprehension, coercion, mean-

178. See Brakel & Davis, supra note 115, at 432.
179. President's Commission, supra note 156, at 175, 186.
181. Id.
ingless formality, and uniform information each address the process of decision-making rather than the specific decision itself. That is, they reflect an overarching objective shared by many persons involved with the passage of the PSDA that individuals be allowed to make their own decisions about the use or nonuse of advance directives. For these persons, the PSDA was intended to give patients accurate and uniform information without creating undue anxiety or pressuring them to execute documents they either did not understand or genuinely want. They believed that if given accurate and uniform information, more patients would execute advance directives.

The state may not always have a compelling interest that overrides a refusal to accept standard psychiatric treatment. However, the state interest in providing treatment to an incompetent person might be so fundamental, such as promoting self-reliance, personal independence, amelioration of delusional thinking, or an avoidance of a person's complete or lifetime dependence on a state institution advance directive. These interests legitimize a state interest without mandating a "clear, convincing or compelling" interest to do so. For example, increased insight through psychotropic medication may lead to better self-control for the patient to prevent self-destructive or anti-social acts.

In exercising the state's parens patriae power, the court must balance a person's legal rights to self-determination with concern for their best interests.

184. See Guardianship of Boyle, 674 A.2d 912, 914 (Me. 1996) (authorizing the Department of Human Services to treat patient a with psychotropic drugs to protect patient from doing harm to herself or others, despite patient's claim of right to personal autonomy).
186. See In re Roche, 687 A.2d 349, 351 (N.J. Super. Ct. Ch. Div., 1996) (citing In re R., 638 A. 2d 1274 (1994)) (reasoning that the balancing test is necessary because "an adjudicated incompetent 'like a minor child, is a ward
[The state has a legitimate *parens patriae* interest in furthering the treatment of those who are mentally ill by forcibly administering psychotropic medications when the patient is not capable of making a sound decision in his own behalf. . . . It is the unquestioned right and imperative duty of every enlightened government, in its character of *parens patriae*, to protect and provide for the comfort and well-being of such of its citizens as, by reason of infancy, defective understanding, or other misfortune or infirmity, are unable to take care of themselves.]

States should enact laws encouraging every individual with mental disabilities to have advance directives to enhance care and to control medical costs. Recently, a federal court, in *Haldeman v. Pennhurst State School*, recognized not only the need and advantages for persons with mental disability to have an advance directive, but also encouraged states to use this effort as a vehicle to enhance civil rights and appropriate treatment.

Empirical studies have shown advance directives have significant limitations. These limitations are particularly acute for persons who become incompetent to make health or mental health decisions and have not appointed a proxy agent. Obviously, advance directives are useful only when a valid one exists and the treatment provider knows about it. Persons suffering from serious mental illness often lack normal resources, such as stable housing, knowledge of legal rights, and the involvement of caring family or friends to encourage them to have an advance directive. Typically, a patient with mental illness is not offered the assistance needed to execute an advance directive for future care, even though the need for psychiatric care is often more intense and frequent than other groups who might be offered such an option by their hospital or physician. This situation might be different for patients being treated within a state operated or licensed mental health

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of the state, and the state’s *parens patriae* power supports the authority of its courts to allow decisions to be made for an incompetent that serve the incompetent’s best interests.

system. Since most mental health care is rendered within a state operated or licensed system, and paid for by public monies, there is more opportunity to discuss the advantages of an advance directive than in general health care. An advance directive, like a Nexum, would more likely enhance principles of beneficence with enhanced patient autonomy in the mental health context due to more frequent and closer relationships with the patient. 191

Fortunately, patients generally trust their physicians and are willing to give them discretion to render treatment as requested, or to modify it as necessary. 192 There is arguably a greater need to plan for future mental health care, a notion that is supported by modern research on the relationship between the biology of the brain and mental illness. Research continues to confirm long held theories that mental illness and impaired decision-making might have an organic connection for certain persons with schizophrenia and bipolar affective disorders. Decision-making incompetence is often inextricably and insidiously intertwined with the symptoms and progress of certain diseases. Indeed, “primary process thinking” is one of the hallmarks of schizophrenia. It has been medically known and legally acknowledged 193 that mental illness can impair the brain’s awareness of the disease. 194 Science is beginning to identify brain dysfunction that is involved in mental illness and how it impairs insight into one’s own illness. 195

Advance directives are considered particularly appropriate in the care of persons with mental illness because of the intermittent nature of the diseases. 196 All fifty states have some form of an advance directive statute for general health care. 197 However, in the general health

193. See, e.g. N.Y. MENTAL HYGIENE, § 9.01 (1999).
194. See E. Fuller Torrey, Protecting the Rights, the Person, and the Public: A Biological Basis for Responsible Action in CHOICE AND RESPONSIBILITY 37, 39 (Clarence J. Sundram, ed. 1994).
196. See Debra S. Srebnik & John Q. La Fond, Advance Directives for Mental Health Treatment, 50 PSYCHIATRIC SERVICES 919, 919-925 (July 1999); see also Paul Appelbaum, Advance Directives For Mental Health Care, 42 HOSP. AND COMM. PSYCHIATRY 983-84 (1991).
197. See infra Chart, Advance Medical Directives & Mental Health Treat-
care system, there is no common point to persuade patients to make an advance directive, except for long-term admissions to nursing homes or possibly during hospital admissions. In contrast, a specialized statute for persons within the mental illness system would have the potential for being a feature integrated into the routine events in a patient’s life such as a discharge or transfer from a facility, rendering a particular service, or during the composition or review of a patient’s service plan. But, advance directives for general health care are not well suited for persons with IMI. Most general health care advance directives are aimed at terminal stages of health treatment where a patient is unlikely to be able to communicate, and is therefore unlikely to revoke the document. However, for the IMI patient, most general health care advance directive statutes do not differentiate between an attempt to revoke by an incompetent patient and an actual revocation by a competent patient.

Efforts to increase the prevalence of physical health advance directives seem to depend largely on increasing physician-patient communication. Indeed, many believe that this is what patients really want and that advance directives can be used as a means of stimulating meaningful communication and mutual respect. Mental health advance directives have a greater potential for success in this regard than those utilized in general health care because the patient’s illness and other conditions are more likely to recur intermittently. The patient, as well as the attending physician, can therefore better describe and tailor the terms of the Nexum. Thus, the Nexum can be used to settle in advance such issues as: types of medications and dosage ranges; methods for handling emergencies and notifications; preferences for particular hospitals and lengths of stay, physicians, or settings for care; identification of dependent persons; willingness to accept “experimental treatments” and a variety of other medical issues. Perhaps most importantly, the Nexum can articulate subjective values of the patient and define the therapeutic relationship with his or her physician. This can be used to maintain the consistency of unexpressed or

198. See Larson & Eaton, supra note 182, at 249-50.
199. See Srebnnik & LaFond, supra note 196, at 923.
201. See Srebnnik & La Fond, supra note 196, at 924.
unforeseen treatments that are necessary.  

An example of how an advance directive statute for general health care can operate contrary to the needs of a person with severe mental illness is the general advance directive law in New York State. This statute gives legal effect to any nullification by a patient, whether that patient is competent or incompetent to make decisions. Thus, a patient who executes an advance directive for the very purpose of controlling his care when incompetent to make a decision, will automatically nullify it with any articulated refusal or withdrawal. As a result, the advance directive is useless in the usual case of the IMI patient. For example, the author was consulted by an attorney; a female client would become IMI, but recovered quickly with a certain psychotropic medication. During her periods of mental decompensation, she acted sexually inappropriate and highly promiscuous; in one instance undressing in a busy shopping mall. She desired to execute an advanced directive to address her plight, but the fact that she would deny her illness and refuse her medication at its onset made using an advance directive meaningless under New York Law.

Empirical studies have shown that many other problems and limitations of advance directives for general health care can be removed, resolved, or greatly ameliorated with specialized mental health advance directives. It has been noted that "[p]roviding patients with accurate, uniform and comprehensible information is a prerequisite for autonomous decision-making." It also makes a difference how and where the information is presented. Hospitals tend to implement advance directives in a perfunctory manner at both ends, i.e., in having patients make them, and in honoring the directive if the hospital discovers its existence for a given patient. Indeed, patients who have advance directives generally do not understand the document's purpose or appli-


203. N.Y. PUB. HEALTH LAW ART. 29-C.


205. Larson & Eaton, supra note 182, at 268.
cation any better than patients who do not have one.\textsuperscript{206} Although most patients would feel more comfortable constructing the terms of their advance directive with their physician prior to a hospital admission, physicians are reluctant to spend non-reimbursable time in such meetings. Additionally, physicians understandably lack the legal training to convert their clinical recommendations into what is essentially a legal document. Yet, there is strong evidence that patients desire to have advance directives, once they understand their uses and advantages.

It is noteworthy that there is no evidence of coercion in getting patients to adopt advance directives, and this is true even for so-called “vulnerable” populations of patients.\textsuperscript{207} There must be a distinction made between use of coercion, which is inappropriate, and the use of strong persuasion or inducements, which are permissible. If it is permissible for one’s attorney to use maximum persuasion for a client to adopt an advance directive,\textsuperscript{208} it is certainly equally legitimate for the state to do so in its role as \textit{pares patriae}.

There are two problems that emerge regarding the execution stage of an advance directive: making the treatment provider aware of the directive, and honoring the terms incorporated within it. Both phases of the advance directives have presented problems. First, physicians are often unaware of the existence of an advance directive because, among other reasons, they are rarely (less than six percent) documented in the patient’s medical record.\textsuperscript{209} However, when physicians do know about an advance directive, they follow its terms seventy-five percent of the time; the “twenty-five percent ‘override rate’ indicating that when the physician’s training and the advance directive conflict, physician preferences generally prevail.”\textsuperscript{210} As seen in the twelve states that have advance directives for mental health treatment, most provide protection for physicians to render treatment that is consistent these good faith and professional standards.

In terms of general health care advance directives, regrettably for

\textsuperscript{206} See id. at 271.

\textsuperscript{207} See id. at 275-76.


\textsuperscript{209} See Larson & Eaton, \textit{supra} note 182, at 280.

\textsuperscript{210} See id. at 279.
both federal and state policies, one researcher predicts that "no amount of intensive interventions can increase the use of written advance care directives beyond twenty-five to thirty percent of the population."\textsuperscript{211} This should not be the case for mental health advance directives, because the mental health system is a self-contained, state-controlled bureaucracy, regulated and funded with public funds (mostly Medicaid, which has an elaborate tracking system for services). Also, IMI patients have repeated contacts with various treatment providers in the mental health treatment system. These patterns of care give the mental health system a unique opportunity to offer advance directives to patients under conditions that avoid the problems discussed above. For example, while the general health care patient might never get aid from their doctor in drafting an advance directive, the mental health system can ensure that this is done during discharge from an institution, admission into an outpatient program or at some other point of contact between patient and service provider. Moreover, since it is necessary that the patient be certified as competent at the time of executing an advance directive, usually by a simple clinical determination rather than a judicial proceeding, the mental health system can easily ensure that a physician performs this function.

There is a concern that some patients will listen to the advice of certain advocates with ideological anti-psychiatric biases who will advise them to use the advance directive to prospectively reject any psychiatric treatment including the use of medications. However, such fears are not likely to present a large problem for a number of reasons. The state will have the distinct advantage of access to the patient with its physicians and support staff, who can generally be more influential on a patient's willingness to adopt advance directives. Advance directives that inhibit or prevent rendering necessary treatment early enough to stem mental deterioration will leave the patient susceptible to more drastic, and presumably less desirable alternatives, such as institutionalization, more serious interventions, or a greater likelihood of a permanent disability. An advance directive must be a practical document that comports with medical practice, ethics, and state laws and regulations. In that regard, most states having a mental health advance directive statute provide forms that can be designed to reduce their non-therapeutic uses.\textsuperscript{212} The sliding scale for patient competency

\textsuperscript{211} Id. at 278.

\textsuperscript{212} See Elizabeth M. Gallagher, \textit{Advance Directives for Psychiatric Care}:
proposed here is partially contingent upon the patient's acceptance of the professionally acceptable standard of care, in effect, deterring other anti-therapeutic advance directives. The patient must be made to realize that use of an advance directive enhances not only his autonomy and self-determination, but also enhances his stability in the community program. Therefore, the patient must be persuaded to agree to an advance directive that addresses his mental health condition and the inherent risks he faces. It is no advantage to have a generic refusal of all treatment; this only guarantees that treatment will probably be rendered eventually, but it will come too late and with little or no input or choice from the patient.

Finally, while it is clear that a patient cannot be coerced to have an advance directive it might be a fair requirement as a condition of participation in a program, it is appropriate for the mental health system to offer certain incentives to the patient. Considerations such as housing and enhanced services can certainly be justified to avoid deterioration, or the possibility of the patient losing a job or social integration in the community. Additionally, it is clearly more appropriate to choose a time when the patient is thinking most clearly and is favorably disposed to having a Nexum. The determination of patient competency by the physicians of the mental health system can act as a gatekeeper in this regard. All of these approaches favor patient treatment within a state mental health system and are consistent with federal and state policies to promote proper treatment and maintain patients in community programs.

Advanced planning by a Nexum can also serve the patient's interests in avoiding stigma. A patient should be involved in his or her

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A Theoretical and Practical Overview for Legal Professionals, 34-55 (in press).

213. See Bruce J. Winick, supra note 166, at 57, 81 n.88 (1996). This article also suggests changing the terms of an advance directive to permit unforeseen but more advantageous treatments by analogizing this modification power to the cy pres doctrine used in testamentary bequests. See id. at 91 n.7.


Incompetency labeling also can be avoided by encouraging individuals to make greater use of advance directive instruments and health care proxies. These arrangements allow individuals to anticipate the possibility of a future period in which their decision-making capacity will be impaired and to execute a formal instrument directing how decisions will be made on their behalf or se-
treatment since it is one of the most important aspects of his or her life.\textsuperscript{215} Being shut out of this decision-making is usually of greatest concern to the patient. Patients are often more concerned with fairness of the overall process, and less on having access to judicial review or resources.\textsuperscript{216} The latter appears to be more a defense to neglectful treatment than a resort to any kind of particular wisdom or expertise by the courts either on mental illness or the patient herself. What the patient often perceives as the benefits of litigation over civil commitment or compelled administration of psychotropic medication is really a demand for more careful and dignified treatment. Rather than applying constitutional mandates theoretically, judges generally make practical decisions about compelling a person to accept mental health treatment, utilizing compassion and traditional values, looking at a patient’s competence, predictability, suicide potential, need for treatment, and the opinions of loved ones, such as family or friends. In practice, judges defer to clinical judgments and let physicians usually make decisions; more medically informed decisions than the typical court hearing.\textsuperscript{217} It does not seem surprising that when judges and physicians behave as would a reasonable parent, adversarial litigation diminishes.\textsuperscript{218} Increased satisfaction with a system would promote physicians trusting patients and patients trusting physicians; for trust engenders cooperation\textsuperscript{219} and cooperation enhances cure.\textsuperscript{220}

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Id.
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\textsuperscript{216} See Miller, \textit{supra} note 171, at 1174.

\textsuperscript{217} See \textit{id.} at 1179.


\textsuperscript{219} See Cathy J. Jones, \textit{Autonomy and Informed Consent in Medical Decision Making: Toward a New Self-Fulfilling Prophecy}, 47 WASH. \& LEE L.
Some have argued that a person cannot surrender his decision-making authority irrevocably when clinically determined to be incompetent. However, this would be a serious denial of autonomy, an especially ill-advised one that is clearly contrary to the patient's well-being. When serious mental illness strikes, there is very often a loss of insight into the illness or the need for treatment. Thus, it is highly desirable, indeed essential, to incorporate irrevocability into such an agreement. As discussed below, all of the twelve states with specialized mental health advance directives require or permit a patient to have terms for irrevocability.

V. DISPUTE RESOLUTION

With knowledge, experience and foresight, Odysseus foresaw an episode in his voyage calling for advanced planning because he knew his decision-making would be so impaired that it could cause his death and the deaths of his crew. This insight helped him survive the experience of the Sirens. Indeed, his advance directive to his crew worked so perfectly that it led to the Sirens destruction.

In personal decision-making, it is largely up to the individual to assess risks and intelligently take chances, even when the possibility of death might be high. Racing cars, climbing mountains, or even more ubiquitous high risk activities such as skiing, scuba diving, sport parachute jumping, and driving an automobile or motorcycle, are considered normative non-objectionable personal decisions as long as the decisions are competently made. In a "Madison Avenue" version of an Odyssean arrangement, there are many public service commercials: "Friends don't let friends drive drunk." The commercial suggests that the keys to the vehicle should be taken from the intoxicated person. This is the equivalent of tying the potentially drunk driver to the mast for his own good and the safety of society. If the driver tells his friends before becoming intoxicated "do not let me drive under any circumstances if I am or appear to be intoxicated," it would expressly be a modern version of the Odysseus contract.


221. See, e.g. Dresser, supra note 230, at 787.
The state may insist on limiting behavior based on a competency test before granting a privilege to a citizen, such as requiring a license for operating a motor vehicle, heavy machinery or possessing a pistol. Sometimes private organizations require competency testing for activities such as scuba diving or parachute jumping. There are times when it is important to know whether a person has the mental or physical competence to undertake a task, because his life and safety or that of others might well hang in the balance. The ownership of firearms is another example where some states have competency requirements, both physical and mental. The state may set general rules for the safety of the individual and others, and deny privileges based on mental or physical incompetency.

For the IMI patient, there will be alternating periods of competence and incompetence, often depending on whether their psychotropic medication regimen is being followed. During periods when a person relapses into severe mental illness, the Nexum can bridge periods of disruption in their lives, reduce the chances of rehospitalization, and maximize personal autonomy. It is important to note that the Nexum differs from other advance directives that have been called “Ulysses” agreements where a patient's true desire to be “lashed to the mast” can be questioned.\footnote{222. See id.; see also Robert Cuco, Note, Ulysses in Minnesota: First Steps Toward a Self-Binding Psychiatric Advance Directive Statute, 78 CORNELL L. REV. 1152, 1154 (1993); Perling, supra note 30, at 204; Winick, supra note 166, at 57.} The Nexum will not only be integrated within the mental health delivery system to overcome some of the problems already discussed, but will feature an administrative adjudication process that has proven to be more effective than a court for deciding issues of patient competency and validity of the advance directive. This administrative adjudication process has many advantages over a court. This system is much more patient-friendly than a typical court because two of its four panel members have direct experience in the mental health area as family members, or even as former patients themselves.

An administrative adjudication system specifically tailored to determine issues of competence and ideally suited for implementation of the Nexum system, is already in place. In the first of its kind in the nation, New York State created a Surrogate Decision-Making Program (SDM), which has for the past thirteen years made decisions regarding major medical treatments (surgery, intrusive diagnosis, etc.) for per-
sons with a mental disability or who are deemed to be incompetent. SDM is composed of four individuals including three professionals, who have a personal interest or training in the care of persons with mental disabilities. In addition, SDM has won two national awards and has become a model for other states. Its decisions have been speedy yet highly accurate. Of thirteen appeals taken from almost four thousand cases decided, only one court found an insufficient record for the SDM panel. The court ultimately agreed upon the finding of incompetency after de novo review of the previous incapacity decision.

In the first ten years of operation and in very limited areas of New York State, SDM has handled 3,561 cases involving 5,646 medical procedures. Sixty-eight percent of the patients (2,242) resided in institutions while thirty-two percent (1,139) came from community residences or programs. Of thirteen appeals taken from almost four thousand cases decided, only one court overturned the finding of incompetency made by the quasi-judicial panel. The average time from filing an application to receiving a decision was 6.3 days. However, certain mandatory notice requirements extended this time period which a Nuxum could reduce. An expedited decision is also available in appropriate cases. Over the past ten years, there were 582 (16%) expedited cases in the ten year caseload.

The SDM program has other advantages that would remove several barriers to the use of advance directives. For example, the SDM staff would have the expertise and resources to collect all relevant patient records from mental health system providers, as well as subpoena


224. See N.Y. MENTAL HYGIENE, § 80.05


226. See Sundram & Stavis, supra note 223, at 120.

227. See id. at 121.

228. See id. at 120-21.
power to obtain records from non-state sources such as private physicians or hospitals. It could be a repository, a coordinator or a search mechanism for a patient's Nexum. Liability based on a claim of a lack of informed consent is greatly reduced because SDM is legally authorized to issue informed consent in the form of a certificate that is valid for a fixed period of treatment. It ensures the dignity of participation by the patient, who has a right to be present unless physically unable, in which case a panel member would visit the patient before the hearing. The cost of the program is almost negligible compared to litigation.\textsuperscript{229}

Although actual costs are difficult to define or obtain for mental health litigation, one estimate of two court hearings to determine a civilly committed patient's competence to refuse psychotropic medications—assuming a full adversarial proceeding with heavy and complex burdens of proof—put costs in addition to the institutional care as $13,000 and $19,000 respectively. This does not include the time of state officials, expert witnesses or other incidental costs.\textsuperscript{230}

The cost of a SDM hearing is far less. At the request of the author the New York State Commission on Quality of Care for the Mentally Disabled (Commission on Quality of Care), the state agency that administers and funds the SDM system, made a rough estimate. By taking the costs and numbers of cases processed in the two busiest counties of New York State, the cost is very likely less than $500 per hearing, the actual number was $392 (including the largest expenditures, such as the cost of support by the Commission to the panels of volunteers, subcontracts with county Dispute Resolution agencies, and all travel expenses and service costs of the panels themselves.\textsuperscript{231}

To decide upon a simple medical procedure, a court proceeding where the hearing was waived cost $1,800 in attorney fees for one


\textsuperscript{230} See Letter of Pat Johnson, Assistant Counsel Commission on Quality of Care, on file with the author, dated November 15, 1999; and \textit{supra} noes 115-117.

\textsuperscript{231} New York State Register, Nov. 3, 1999, at 9. “Regulatory Impact Statement by the Commission on Quality of Care,” paragraph 4. “Costs.” (Stating that in one case for a judicial hearing for a simple medical procedure there was $1,800 in attorney fees alone, even though the hearing itself was waived.)
party to the proceeding alone.\textsuperscript{232} These costs compel a common sense conclusion that an effective administrative dispute process run under the auspices of a state agency is far less expensive than to a full judicial hearing, and does the job better in most cases. In the minority of cases where the issues are novel, contentious, or particularly susceptible to a full adversarial hearing, judicial appeal and a trial \textit{de novo} is available from the SDM determination. Further, there is no cost to the patient or provider; the panel members are reimbursed for travel expenses only, and the state provides the SDM staff.

SDM "patient-friendly" operates in a much more informal atmosphere that is less likely to intimidate the patient or staff, unlike a formal courtroom.\textsuperscript{233} Some commentators argue strongly for utilizing an advance directive and SDM option based on the growing discipline of law and economics. It seeks to minimize the costs of the decision-making system to both the patient and the social system.\textsuperscript{234} This type of analysis, and the performance of the judicial versus administrative programs like SDM, leave little doubt that the latter performs better on every indicator: accuracy, error reduction, participant satisfaction, low economic cost, and most of all, maximizing patient autonomy. SDM panel members are people with hands-on experience in the areas of mental illness, dealing with patients on a personal level. Unlike a generalist judge who handles many different legal issues, SDM is highly specialized and is solely concerned with the patient's rights and treatment.

The Nexum, operating in the context of an alternative dispute resolution framework, would be formulated through a team approach involving the patient, his physician, program staff and any advocate or friend the patient might want or feel comfortable having with him. There would be two essential features. First, there would be a definition of either incompetence or another condition that makes the Nexum spring to life and become operational. This definition would, of course, have to be consistent with law and professional standards

\textsuperscript{232} See \textit{id}.

\textsuperscript{233} See \textit{JEROME FRANK, COURTS ON TRIAL} 40 (1950).

\textsuperscript{234} See Paul S. Appelbaum & Warren F. Schwartz, \textit{Minimizing the Social Cost of Choosing Treatment for the Involuntarily Hospitalized Mentally-Ill Patient: A New Approach to Defining the Patient's Role}, 24 \textit{CONN. L. REV.} 433 (1992). This economic approach to balancing rights and resources suggests that legal procedures have distinct diseconomies in an increasingly resource-poor governmental physical and mental health care system.
and ethics as well as operational and practical for treatment providers. It will be individualized to the patient's needs and circumstances of his treatment and may not only involve a medical or behavioral condition, but also the feature of a proxy where a trusted person or physician can declare the need for treatment or be used in a guardianship fashion to declare the patient to be in need of treatment as per his or her Nexum.

Second, the Nexum will specify to a reasonable degree the course of treatment that has received the patient's consent. It may contain alternative treatments and should have language that permits for change based upon unanticipated circumstances. In this regard, the Nexum will have standardized provisions or it will be required by law to permit review by an administrative adjudication panel for any disputes, such as the determination of competency or divergence from the terms of the advance directive for a showing of good cause. Beyond these terms, there will also be standard legal provisions for revoking previous advance directives, a statement of general intent, a "hold harmless" provision for those assisting the patient or executing the advance directive in good faith and with negligence or intentional misconduct, etc. 235

Up to this point, the philosophical and conceptual basis for the Nexum has been developed. This section will introduce and explain draft legislation (See Appendix C) for authorizing it. It will utilize as its basis the two statutes in New York State – the advance directive statute for general health care236 and Surrogate Decision Making Committee (SDMC) statute for initial dispute resolution. 237 These statutes have been chosen for three reasons: (1) New York and Texas are currently the only two states that have an SDMC type program; (2) New York's general advance directive law is typical of many and contains all the essential legal elements; and (3) the familiarity of the authority with both statutes particularly as an author of the SDMC law and chief legal advisor to the program.

The chart of the twelve states with mental health advanced direc-

235. See Davis, supra note 98, at 52-54 (showing a multiple choice form for advance directive) (McKinney 1988).
236. NY PUBLIC HEALTH ART. 29-C (McKinney 1988). This statute does address treatment of mental illness, but permits revocation by a mentally incompetent patient unless a court proceeding is brought and an order obtained.
237. NY MENTAL HEALTH ART. 80.
tives compares ten characteristics. This first one, irrevocability while a
patient is incompetent as clinically, not necessarily judicially, deter-
mined, is the essential difference between mental health and general
health care advance directives. A variety of methods are available for
making a credible determination of patient competency without having
to resort to a court ab initio. Indeed, line 5 of Chart A gives a sum-
mary of these different methods. While half of the states (Alaska,
Idaho, Oregon, South Dakota, Texas and Utah) use courts as one al-
ternative method to determine competency, a clinical determination is
permitted by most states. Eleven of the twelve define incompetence as
the inability or incapacity to make or communicate mental health care
decisions.238 All of these formulae could be accommodated in the
Nexum, with the preference for either a patient’s own definition of his
or her need for treatment or the appointment of a trusted person to
make that call which would then be ratified by treatment professionals
under law and their professional code of ethics.239
Ten of the twelve states provide for a proxy. This is surely an option
that should be offered. In the Nexum it might also be used by a pa-
tient to delegate the power to a proxy to declare the patient to be in
need of treatment as specified in the Nexum. This is the most tradi-
tional method of surrogate consent. If the patient has strong trust in a
spouse, other family member, close friend, trusted lawyer, or even a
physician who is involved in the instant treatment, etc., it would be
advantageous for both the patient and the provider of treatment by re-
moving most uncertainty when the Nexum is executed. Of course, the
treating physician or provider would have to agree that the patient is
incompetent to make treatment decisions and that the treatment is ap-

239. George J. Annas and Joan E. Densberger, Competence to Refuse
Medical Treatment: Autonomy vs. Paternalism, 15 U. TOL. L. REV. 561, 584
(1984)
Competence is primarily a fact question that can be answered
without reference to medical expertise. Properly understood, a
relative, a friend, a nurse, or any other person familiar with the in-
dividual and the standard of competence should be able to make a
reasonable assessment... What matters most in making a decision
about what will be done to the body of another is that the values
and will of the patient are honored.
Id.; see also Larson & Eaton, supra note 182, at 286 (citing the UNIFORM
HEALTH-CARE DECISIONS ACT, § 5(c) (Pt.1), which suggests placing decision-
making power with “an adult who has exhibited special care and concern for
the patient; who is familiar with the patient’s personal values, and who is rea-
sonably available.”)
propriate. The issue of overriding the terms of the advance directive is treated very differently among the twelve states, some requiring a court to approve treatments unauthorized by the patient and others permitting physicians to trump the advanced directive if the treatment is contrary to customary practices or ethical considerations. This problem is particularly suited to the Nexum because it will incorporate an effective and well regarded quasi-judicial determination, that is essentially like an administrative law process that has been held constitutional for such purposes as making competency determination for psychiatric treatment over objection from the patient. As a matter of both ethics and practicality, it makes sense to provide some authority to the treating physician to refuse to follow an advance directive based on the physician's professional or personal ethics, or based upon customary medical practice. Studies of advance directives have shown that physicians will not deviate from the standards of the medical profession as they understand them, and will therefore ignore or modify the expressions of the advanced directive accordingly. A related issue is whether there will be reasonable limits to liability for both the provider of treatment and any proxy who follows the advance directive in good faith. Most of the twelve states provide for limited immunity from being sued for either refusing or rendering requested care.

The issue of how the provider is alerted to the advance directive has been problematic, especially for general health care since there are no provisions for a central registry and a requirement that it be consulted before treating a patient. For the twelve states with mental health advance directives, there is little improvement—all but one puts the responsibility on the patient to deliver it to the physician. This is a dubious proposition for someone who will probably, if not by definition of needing an execution of the terms of his or her advance directive, be mentally incapacitated and therefore unlikely to alter the physician. The Nexum offers an improvement in having a central registry in the state office of mental health, or in a similar location that can be

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241. See Larson & Eaton, supra note 182, at 267.
easily accessed by physicians. Moreover, a physician, or a mental health administrator, licensee or provider who was about to treat a patient would have a great incentive in doing so because it would make the treatment situation, such as obtaining informed consent, easier and more certain.

Providing an official form by statute or regulation is important. For a mental health advance directive, this is essential as evinced by the fact that ten of the twelve states provide a form in their statute. The Nexum must contain certain provisions to make it effective. There are two in particular that are necessary. There must be appropriate language that refers disputes to the SDMC program, and more significantly, there must be appropriate parameters of patient choice and system guarantees. The patient must select treatments that are both effective and within professionally acceptable standards. The treatment provider, either the state itself or an agent of the state, must render treatment that does not significantly deviate from professional standards under constitutional law. It obviously does not benefit a patient to request treatment that is not beneficial and effective, that will be resisted to as anti-therapeutic by the treatment provider, or that will fail to deter further mental deterioration and thereby jeopardize the patient's freedom by being subjected to the civil commitment process or some other form of compulsory treatment chosen by someone else. Standardization of language will also avoid unnecessary ambiguities on very important issues.

There should also be a provision to protect physicians from having to deviate from customary practices. As a *quid pro quo* for justifiable refusal by a physician to treat the patient, some statutes require transferring the patient to another treatment provider. Studies have shown that it is most likely for a physician to override advance directives

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244. See Youngberg, 457 U.S. at 324.
245. It is beyond the scope of this Article to produce a specific form or language for the Nexum. The matter of a form is one that should be addressed in a statute or regulations of the department of mental health. There are excellent examples of forms for a mental health advance directives in many of the statutes in Chart, Advance Psychiatric Directive State Statutes infra, as well as a very comprehensive form prepared by Joe Cooney of University Legal Services and distributed by The Commission on Mental Health Services. (May 17, 1999). See also Elizabeth M. Gallagher, *Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals* (in press 1999).
where there is a conflict in treatment standards and patient preferences; in such instances, physicians usually prevail.\textsuperscript{246} Thus, it would be up to the patient’s primary physician, or perhaps the patient’s case manager, to become aware of this problem and seek appropriate alternatives.

Finally, there is the important issue of making both the treatment provider and the patient aware of the option of having an advance directive. This problem has made advance directives appear “irrelevant.”\textsuperscript{247} As discussed above, this is one of the biggest problems preventing wide usage of advance directives within the general health care/hospital system, a solution which might save as much as $100 billion in terms of end-of-life medical treatments.\textsuperscript{248} With patients being treated by the state’s mental health system, however, there might be greater success if there is a state program to strongly encourage their use. Such patients would see various state-licensed treatment providers routinely, especially to maintain their psychotropic medication regiment. Patients are much more likely to want an advance directive if they can meet with their physician to discuss the treatment.\textsuperscript{249} They also might have case managers who could explain the advantage of this option for their care and maintaining their lifestyle. Attaining familiarity with the patient within the treatment system, the reimbursement system and with program staff, advance directives could routinely be made a part of their patient discharge, admission, treatment and importantly records processes and automatically brought to the attention of the respective treatment provider.

The Nexum would be an instrument that works within a “comfort zone” of familiar or trusted individuals, using treatments that have worked before and been found acceptable to the patient. The patient would have to understand the needs of the treatment system and incorporate the judgments and advice of case managers and treatment professionals to ensure that the advance directive is workable and acceptable to others who will be involved in its implementation. This process of advance planning would be empowering for the patient.\textsuperscript{250} The com-

\begin{itemize}
  \item \textsuperscript{246} See Larson & Eaton, supra note 182, at 279.
  \item \textsuperscript{247} See id. at 280.
  \item \textsuperscript{248} See id. at 282-92.
  \item \textsuperscript{249} See id. at 274. “[M]ost studies indicate that patients overwhelmingly favor receiving PSDA [advance directive] materials, especially if given by physicians or nurses.” Id.
  \item \textsuperscript{250} See Winick, supra note 166, at 81-85.
\end{itemize}
fort zone would also include a new administrative approach to resolving issues having to do with the advance directive and its implementation.

For the person with severe mental illness living in a community with support services, the greatest danger to freedom is becoming intermittently incapacitated because of a failure to maintain stabilization through medication. During cyclic periods where the patient is not maintaining his medications, or the medication is no longer suppressing psychotic symptoms, is it not the interests of the state and the patient to curtail the interruption in community freedom? The state has a legitimate interest and a right to ensure both the welfare of the patient and the good order of the community. The patient certainly gets no therapeutic benefits from having a court hearing, which is largely designed only to eliminate gross error in the state’s determinations concerning treatment.

Both of these interests can best be served by the patient’s own exercise of treatment preference, while competent, via an advance directive. The advance directive should be a workable arrangement that is consistent within the range of professionally acceptable treatments and the state regulated system of care and treatment. The result will be to maximize patient autonomy and mental health, while minimizing the social costs of treating the mental illness.

VI. CONCLUSION

The development of the contract can be characterized as the beginning of economic freedom and a necessary precursor of civil liberty, if not the charter in terms of permitting individuals to define their legal interrelationships. It is no exaggeration to state that contract has been a foundation stone of Western culture and society— one which permits individual autonomy over the conduct of their personal and business affairs.

The Nexum requires reasonable concessions from the patient and the mental health treatment system. It asks the patient to choose among professionally acceptable treatments and that the treatment system promise to honor those choices in good faith, or present any changed circumstance to a trustworthy and patient-friendly panel that will decide the proper course of treatment using a combination of substituted judgment and patient best interests. If all goes well, the patient
will get the treatments he or she finds acceptable, will minimize or in many cases eliminate the likelihood of hospitalization, and reinforce their place in the community, in their jobs or with their loved ones. In exchange, the mental health treatment system will largely reduce the need to turn to costly and ineffectual litigation and be better able to render more effective and cost-efficient treatment. This will build a therapeutic alliance with the patient and physician because both will benefit from it.

These consequences resulted not of a plan, but of their own accord in New York State’s Pilot Study of an “assisted outpatient treatment” law at Bellevue Hospital in New York City. There, coercion was found to be totally unnecessary over the entire three-year course of the study involving approximately 150 patients. Rather, physician-patient relationships occurred naturally because both patient and treatment system desired to avoid needless litigation. Together the physicians and patients agreed to plans of treatment, which were bonded by incentives that dignify, not dehumanize, the patient. This proved to be successful in maintaining all patients in the community since was neither during the study, nor were there any instances of violence by any patient. In a sense, this pilot study succeeded by its own failure. It was ostensibly to test outpatient commitment procedures, but instead created de facto advance directives of the Odyssean type. It is important to note that this study included more than medical services such as housing, case management, etc.

Patients feeling strongly about determining the course of their treatment, or having particularly negative or positive feelings about a specific treatment, or intervention, will have the option of making advance decision that will effectuate their wishes. Doing so in a way that the law will honor will provide a measure of predictability that may reduce stress and anxiety that might otherwise be devastating. Being able to plan in advance about important matters with the assurance that those plans will be respected and effectuated brings a measure of ease that can permit the patient to pursue happiness and attempt to secure the blessings of liberty in a way that the anxiety and fear produced by uncertainty in such matters might well prevent. Patients may thereby be liberated to maximize their potential for a healthy adjustment to life. Dealing with such an important matter in an effective way also predictably will
promote patients’ self-esteem, which may increase their decision-making capacity generally and their ability to act effectively.

Acting and being treated as self-determining individuals with authority over their own fate, instead of powerless and incompetent victims of forces beyond their understanding and control, can be therapeutically advantageous. Restoration of mental patients to as high a degree of community functioning as is possible in the circumstances should be a significant goal of any sensible system of mental hospitalization and treatment, and this goal will be furthered by allowing patients to make decisions. By contrast, being treated as an incompetent subject of paternalism can foster feelings of incompetency, reinforcing expectancies that might well keep such patients in the psychiatric sick role.²⁵¹

Resources spent on litigation obviously subtract resources from treatment and other services which are in desperate need. Courts have been overly concerned about the type of abuse that is typical of a bygone government operated institutional system. What the courts do not sufficiently appreciate, as Odysseus did, is that genuine freedom can be enhanced, by a short period of restriction to sustain a longer period of stability, health, and longevity. Freedom to pursue happiness necessarily includes the ability to do so in good health. Therefore, a person’s rights of autonomy ought to include the power to give sensible permission to others that might result in a temporary restriction of freedom. If such authority is given while the principal is competent and when the rationality of its purpose is clear to those acting on the principal’s wishes, then the government authority shall promote it. Neither Odysseus nor the crew under his command had any doubt about what their King was doing, perhaps some were envious that they could not also experience the Siren’s sweetly singing. There should also be no doubt that a patient can waive his rights to have a court determine his competency in favor of doing it him or herself through a contract with treatment providers backed-up by an administrative process. Congress has established advance directives as national health policy. The Nexum takes this concept one practical step further by suggesting that they be made in a contractual form. In this way, the

patient is bound to the treatment system, but also the treatment system is bound to the patient. This is the classic contract where both parties are given assurances that their preferences will be followed.
MODEL STATUTE

ARTICLE 83

MENTAL HEALTH CARE AGREEMENTS, AGENTS AND PROXIES

§ 83.01 Legislative findings and purpose.

The legislature hereby finds and declares that timely access to health care for people who are mentally disabled is an important objective for New York State. This goal is best achieved by preserving and protecting the decision-making autonomy of persons who intermittently become incapacitated to make mental health care decisions. Persons with decision-making capacity to make mental health care decisions for themselves should be given the opportunity to do so prospectively for times when they cannot do so because of impairments associated with mental or physical illness. This will ensure that health care decisions are based on the best interests of the patient and reflect, to the extent possible, the patient's own personal beliefs and values. The legislature further finds and declares that the public interest will be served by extending the availability to persons with recurring incapacities caused by mental illness of a specialized advanced directive in the form of a contract which incorporates the quasi-judicial surrogate decision-making process of Article 80. Under this process a patient, in cooperation with the state, or its licensed treatment providers, determines the conditions of his or her incapacity to consent to or refuse medical treatment and the acceptable treatments that are consistent with appropriate mental practices and applicable laws. If there are any disputes, ambiguities or other issues which are not reasonably controlled by the agreement then resort may be made to the Surrogate Decision Making Committee under article 80 of this chapter as to whether the proposed treatment promotes the patient's best interests and is consistent with the patient's values and preferences as articulated in the agreement.

The Legislature finds that such a system will strengthen the surro-
gate decision-making role of parents and others, such as family members, while assuring that those individuals without available family members have access to mental health care which they choose in a timely and appropriate fashion.

§ 83.02 Definitions.

The following words or phrases, used in this article, shall have the following meanings, unless the context otherwise requires:

1. "NEXUM" means an agreement between a person with decision-making capacity and the New York State Office of Mental Health, or any one of its licensees, authorized agents or physicians designating the terms of his or her incapacity due to the onset of mental illness and those medically reasonable treatments that are acceptable to the patient under those circumstances. The state or its authorized licensee or agent will agree to honor this agreement in good faith. In the case of any dispute, ambiguity, or changing circumstances, the state or licensee will document such reasons for deviating and present the matter to a Surrogate Decision Making Committee under Article 80 for a binding decision.

2. "Adult" means any person who is eighteen years of age or older, or is the parent of a child, or has married.

3. "Attending physician" means the physician, selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient. Where more than one physician shares such responsibility, or where a physician is acting on the attending physician's behalf, any such physician may act as the attending physician pursuant to this article.

4. "Capacity to make mental health care decisions" means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed mental health care, and to reach an informed decision.

5. "Principal" means a person who has executed a Nexum.

6. "Agent" is a proxy decision maker appointed under the Nexum.

§ 83.03 Use of a Nexum agreement to specify incapacity, designate acceptable treatments, appoint a health care agent or a mental health care proxy.
1. Authority to appoint agent; presumption of competence. A competent adult may enter into a Nexum agreement that may: (a) specify terms of decision-making incapacity associated with mental illness and consequential need for treatment of mental illness; (b) designate acceptable treatments for which this agreement will constitute valid informed consent; or (c) appoint a mental health care agent to make such decisions on the principal’s behalf. For the purposes of this section, every adult shall be presumed competent to execute a Nexum agreement unless such person has been adjudged incompetent or incapacitated to make decisions concerning the existence or a serious mental illness and the need and consent to such treatment for that mental illness by two physicians, or is currently under guardianship of the person.

2. NEXUM; execution; witnesses.

(a) A competent adult may execute a Nexum agreement by signing and dating it in the presence of two adult witnesses who shall also sign the proxy. Another person may sign and date the Nexum for the adult if the adult is unable to do so, at the adult’s direction and in the adult’s presence, and in the presence of two adult witnesses who shall sign the Nexum. The witnesses shall state that the principal appeared to execute the proxy willingly and free from duress. If the Nexum appoints an agent, then the person so appointed shall not act as witness to execution of the mental health care proxy.

(b) For persons who reside in a mental hygiene facility operated or licensed by the office of mental health, at least one witness shall be an individual who is not affiliated with the facility and, if the mental hygiene facility is also a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law, at least one witness shall be a qualified psychiatrist.

3. Restrictions on whom may be appointed as agent or proxy and the limitations on such mental health care agent.

(a) An operator, administrator or employee of a mental hygiene facility or mental hygiene portion of a general hospital may not be appointed as a health care agent by any person who, at the time of the appointment, is a patient or resident of, or has applied for admission to such facility.

(b) The restriction in paragraph (a) of this subdivision shall not apply to:

(i) an operator, administrator or employee of such facility or hos-
pital who is related to the principal by blood, marriage or adoption; or

(ii) a physician, subject to the limitation set forth in paragraph (c) of this subdivision, except that no physician affiliated with a mental hygiene facility or a psychiatric unit of a general hospital may serve as agent for a principal residing in or being treated by such facility or unit unless the physician is related to the principal by blood, marriage or adoption.

(c) If a physician is appointed agent, the physician shall not act as the patient’s attending physician after the authority under the health care proxy commences, unless the principal expressly states in the Nexum his or her preference for the physician to be the proxy.

4. Commencement of Nexum Operation and Execution of its Terms. The terms of the Nexum shall commence, including the authority of any agent appointed thereunder, upon a determination, made pursuant to this subdivision of this article, that the principal lacks capacity to make mental health care decisions and is in need of care and treatment as defined in section 9.01 of this article.

5. Nexum, contents, form and terms.

(a) The office of Mental Health shall promulgate regulations and policies to educate those treated by the state operated mental health system, train personnel to assist patients to have a Nexum and to develop a proper legal form of the Nexum. The Form shall include language to:

(i) identify the principal, agent, if any and the representative or licensee of the Department of Mental Hygiene;

(ii) if applicable, indicate that the principal intends the agent to have authority to make health care decisions on the principal’s behalf;

(iii) if no agent is appointed to make the decisions on the onset of incapacity associated with mental illness and the need for treatment, then the principal shall designate the terms of decision-making incapacity, need for treatment and those treatments that are acceptable and prospectively consented to;

(iv) the representative of the Department of Mental Hygiene or its licensee will ensure that the specifications of incapacity and treatments designated as acceptable to the principal are practical, appropriate under law and professionally acceptable standards or customary and reasonable medical practices and agrees to honor the principal’s stated wishes in good faith and to refer any dispute, ambiguity or deviation from the Nexum to a Surrogate Decision Making Committee
pursuant to article eighty of the mental hygiene law.

(b) The Nexum may include not only the principal's specific instructions about health care decisions, and limitations upon the agent's authority, but it may also state the principle's wishes, personal values, mental health care goals, or any other statements that would be pertinent and useful in interpreting and understanding the import and effect of the Nexum either for the treating physicians and providers of care or for the Surrogate Decision Making Committee in the event that issues are presented to it.

(c) The health care proxy may provide that it expires upon a specified date or upon the occurrence of a certain condition. If no such date or condition is set forth in the proxy, the proxy shall remain in effect until it is revoked under circumstances where the principal is competent or has capacity to make mental health care decisions. If, prior to the expiration of a proxy, the authority of the agent of the treatment for the current episode of mental illness has commenced, the Nexum shall not expire while the principle lacks decision-making capacity. Such lack of capacity may be determined by the terms of this article or by order of a court of law.

§ 83.04. Rights and duties of Nexum agent.

1. Scope of authority. Subject to any express limitations in the Nexum and without prior judicial proceedings, an agent shall have the authority to make any and all mental health care decisions on the principal's behalf that the principal could make for any treatments that are within professionally acceptable standards or customary and reasonable medical practices. Such practices shall include, but not be limited to: (a) consent for the administration of psychotropic medications; (b) consent to admission to a psychiatric facility for up to two weeks for purposes of either psychiatric evaluation or treatment; or (c) consent for electroconvulsive therapy, unless otherwise limited by the Nexum.

2. Decision-making standard. After consultation with a licensed physician, registered nurse, licensed clinical psychologist or certified social worker, the agent shall make health care decisions: (a) in accordance with the principal's wishes, including the principal's religious and moral beliefs; or (b) if the principal's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the principal's best interests;
3. Right to receive information. Notwithstanding any law to the contrary, the agent shall have the right to receive medical information and medical and clinical records necessary either to make informed decisions regarding the principal's mental health care or to ascertain the principal's medical or mental health condition;

4. Priority over other surrogates. Health care decisions by an agent on a principal's behalf pursuant to this article shall have priority over decisions by any other person, except as otherwise provided in the Nexum or in this article. For any purposes of proceedings before the Surrogate Decision Making Committee under article eighty, the agent shall be deemed a "correspondent" under section 80.03 and have all the rights and privileges of a "guardian" under section 80.07.

§ 83.05. Determination of lack of capacity to make health care decisions for the purpose of empowering the Nexum or the Nexum agent.

1. Determination by attending physician.

(a) A determination that a principal lacks capacity to make health care decisions shall be made by the attending physician and a qualified psychiatrist or psychologist who has no connection in the patient's treatment or any ethical conflict of interest in making such a determination. It shall be made to a reasonable degree of medical certainty. The determination shall be made in writing and shall contain the attending physician's opinion regarding the cause and nature of the principal's incapacity as well as its extent and probable duration and the determination by the psychiatrist that the terms of the Nexum have been complied with to a reasonable degree of medical certainty. These determinations shall be included in the patient's medical record.

(b) If an attending physician of a patient in a general hospital or mental hygiene facility determines that a patient lacks capacity because of mental illness or because of developmental disability, the attending physician who makes the determination must notify the Nexum agent or any correspondent of the patient known to be interested or involved in his or her care.

2. Request for a determination. If requested by the Nexum agent, an attending physician shall make a determination regarding the principal's capacity to make mental health care decisions for the purposes of this article.
3. Notice of determination. Notice of a determination that a principal lacks capacity to make mental health care decisions shall promptly be given: (a) to the principal, orally and in writing, where there is any indication of the principal’s ability to comprehend such notice; (b) to the Nexum agent; (c) if the principal is in or is transferred from a mental hygiene facility, to the facility director; and (d) to the guardian for the principal.

4. Limited purpose of determination. A determination made pursuant to this section that a principal lacks capacity to make health care decisions shall not be construed as a finding that the patient lacks capacity for any other purpose.

§ 83.06. Surrogate Decision Making Committee Resolve all Disputes.

1. Priority of principal’s decision. Under circumstances where there is a determination pursuant to this section that the principal lacks capacity to make mental health care decisions and where a principal or agent objects to that determination of incapacity or to any other mental health care decision made by an agent, the principal’s objection or decision shall be referred to the Surrogate Decision Making Committee pursuant to article eighty of this chapter.

2. Confirmation of lack of capacity. The attending physician shall confirm the principal’s continued incapacity before complying with a Nexum agent’s mental health care decisions, other than those decisions made at or about the time of the initial determination made pursuant to subdivision one of this section. The confirmation shall be stated in writing and shall be included in the principal’s medical record.

3. Effect of recovery of capacity. In the event the attending physician determines that the principal has regained capacity, the authority of the agent shall cease, but shall recommence if the principal subsequently loses capacity as determined pursuant to this section.

§ 83.07 Provider’s Nexum obligations.

1. A mental health care provider who is provided with a mental health care proxy shall arrange for the proxy or a copy thereof to be inserted in the principal’s medical record if the mental health care proxy has not been included in such record. The Department of Mental
Health shall create a central file of such mental health proxies and require and regulate their filing.

2. A mental health care provider shall comply with mental health care decisions made by an agent in good faith under a mental health care proxy to the same extent as if such decisions had been made by the principal, subject to the limitations below.

3. Notwithstanding subdivision two of this section, nothing in this article shall be construed to require a mental hygiene facility, a private hospital, or any physician to honor a nexum or an agent's health care decision made pursuant to it, that the hospital or physician would not honor if the decision had been made by the principal because the decision is: 1) contrary to a formally adopted policy of the hospital that is expressly based on religious beliefs or sincerely held moral convictions central to the facility's operating; 2) contrary to either the acceptable standard of the medical profession or its ethics; or 3) contrary to sound medical opinion; provided that 4) if the treatment will not cannot be rendered according to the Nexum then:

(a) the patient shall be transferred promptly to another mental hygiene facility, or a hospital that is reasonably accessible under the circumstances and is willing to honor the terms of the Nexum that are at issue in the agent's decision. If the agent is unable or unwilling to arrange such a transfer, the Department of Mental Health or treating medical hygiene facility or provider involved in this matter may intervene to facilitate such a transfer. If such a transfer is not effected, the mental hygiene facility or hospital shall seek judicial relief or in good faith attempt to honor the agent's decision.

4. Notwithstanding subdivision two of this section, nothing in this article shall be construed to require an individual as a health care provider to honor an agent's mental health care decision that the individual would not honor if the decision had been made by the principal because the decision is contrary to the individual's religious beliefs or sincerely held moral convictions, provided the individual health care provider promptly informs the health care agent and the hospital of his or her refusal to honor the agent's decision. In such event, the hospital shall promptly transfer responsibility for the patient to another individual mental health care provider willing to honor the agent's decision. The individual health care provider shall cooperate in facilitating such transfer of the patient.
§ 83.08 Revocation.

1. Means of revoking Nexum.
   (a) A competent adult may revoke a mental health care proxy by notifying the agent or a mental health care provider orally or in writing or by any other act evidencing a specific intent to revoke the Nexum.
   (b) For the purposes of this section, every adult shall be presumed competent unless determined otherwise pursuant to the Nexum under the procedures of section 83.05 herein.
   (c) A Nexum shall also be revoked upon execution by the principal of a subsequent Nexum.
   (d) The creation by the principal of written wishes or instructions about mental health care, or limitations upon the agent's authority, shall not revoke a Nexum unless such wishes, instructions or limitations expressly provide otherwise. Such wishes, instructions or limitations shall constitute evidence of the principal's wishes for purposes of any proceeding under Article 80 of this chapter (Surrogate Decision Making) or any judicial or administrative proceedings relating to the Nexum.
   (e) The appointment of the principal's spouse as mental health care agent shall be revoked upon the divorce or legal separation of the principal and spouse, unless the principal specifies otherwise.

2. Duty to record revocation.
   (a) Any having a duty to file the Nexum and has such a file, when they are informed of or provided with a revocation of a mental health care Nexum shall immediately (i) record the revocation in the principal's medical record and (ii) notify the agent and the medical staff responsible for the principal's care of the revocation.
   (b) Any member of the staff of a mental health care provider informed of or provided with a revocation of a Nexum pursuant to this section shall immediately notify a physician of such revocation.

§ 83.09 Immunity.

1. Provider immunity. No health care provider or employee thereof shall be subjected to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring in good faith a mental health care decision by an agent, or for other actions taken in good
faith pursuant to this article.

2. Agent immunity. No person acting as agent pursuant to a mental health care proxy shall be subjected to criminal or civil liability for making a health care decision in good faith pursuant to this article.

§ 83.10 Liability for mental health care costs. Liability for the cost of health care provided pursuant to an agent’s decision shall be the same as if the mental health care were provided pursuant to the principal’s decision.

§ 83.11. Requiring or prohibiting execution of proxy. No person may require or prohibit the execution of a mental health care proxy by an individual as a condition for providing health care services or insurance to such individual. However, this requirement does not prohibit incentives or attempt to persuade patients to execute a Nexum.

§ 83.12 Special proceeding authorized. The mental health care provider, the conservator for, or committee of the principal, members of the principal’s family, a correspondent of the principal as defined in this subsection, or the commissioner of health, mental health, or mental retardation and developmental disabilities may commence a proceeding under Article 80 of the Mental Hygiene Law or if a surrogate panel is not reasonably available then a special proceeding, in a court of competent jurisdiction, with respect to any dispute arising under this article, including, but not limited to, a proceeding to:

1. determine the validity of the mental health care proxy;
2. have the agent removed on the ground that the agent (a) is not reasonably available, willing and competent to fulfill his or her obligations under this article or (b) is acting in bad faith; or
3. override the principal’s or agent’s decision about health care treatment on the grounds that: (a) the decision was made in bad faith or (b) the decision is not in accordance with the standards of the medical profession or are not in the best interests of the patient.
## Advance Psychiatric Directive
### State Statutes

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<td>755 ILCS 43/1 - 43/115</td>
<td>348 § 1101</td>
<td>252B.03(6)(b)</td>
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<tr>
<td>(1) Incompetent revocation of advance directive permitted?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>(2) Official form?</td>
<td>Yes 47.30.970</td>
<td>Yes 327F-8</td>
<td>Yes 66-613</td>
<td>Yes 4375</td>
<td>No, sample form provided at 1101(d)</td>
<td>N/A</td>
</tr>
<tr>
<td>(3) Modifications permitted?</td>
<td>Must be substantially in the same form</td>
<td>Must be substantially in the same form</td>
<td>Must use form or language that is &quot;substantially similar&quot;</td>
<td>&quot;a person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions...&quot;</td>
<td>&quot;a person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions...&quot;</td>
<td>&quot;a person who suffers from a psychotic condition who is temporarily impaired by reason of having lapsed back into that psychotic condition to the extent that while temporarily impaired, the person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the person's health care.&quot;</td>
</tr>
<tr>
<td>(4) Criteria of incompetence:</td>
<td>&quot;any person suffering from a psychotic condition who is temporarily impaired by reason of having lapsed back into that psychotic condition to the extent that while temporarily impaired, the person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the person's health care.&quot;</td>
<td>&quot;a person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions...&quot;</td>
<td>&quot;a person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Who makes determination of incompetence?</td>
<td>a. court b. two physicians that include a psychiatrist c. one psychiatrist and a professional mental health clinician</td>
<td>a. Court b. two physicians that include a psychiatrist c. a psychiatrist and a professional mental health clinician</td>
<td>a. two physicians b. court</td>
<td>a. two physicians b. court</td>
<td>two physicians, including the attending physician</td>
<td>Not specified in this §; must see code for health directives</td>
</tr>
<tr>
<td>(6) Proxy option available?</td>
<td>Yes 47.30.952</td>
<td>No</td>
<td>Yes 66-602, 66-601 (mandatory)</td>
<td>Yes 4375</td>
<td>For guardianship, 1101(16)</td>
<td>Yes 213B.09(3)(b)</td>
</tr>
<tr>
<td>(7) How is provider alerted to advance directive?</td>
<td>Patient delivered 47.30.958</td>
<td>Patient delivered 327F-6</td>
<td>Patient delivered</td>
<td>Patient delivered</td>
<td>Patient duty to deliver</td>
<td>Needs to be delivered to mental health treatment provider</td>
</tr>
<tr>
<td>(8) Who can overrule advance directive terms?</td>
<td>Not specified</td>
<td>a. Court in commitment to treatment facility b. emergency 66-609</td>
<td>a. Court order to override b. emergency 43/45(1)</td>
<td>a. Court order to override b. emergency 43/45(1)</td>
<td>Attending physician</td>
<td>a. if committed, need court order to override and b. if not committed, provider must seek commitment and court order for treatment. Not specified</td>
</tr>
<tr>
<td>(9) Is there proxy immunity for criminal/civil liability?</td>
<td>Yes 47.30.958</td>
<td>No specified</td>
<td>Yes 66-606(4)</td>
<td>Yes 43/30(3)</td>
<td>Not specified</td>
<td>Not specified</td>
</tr>
<tr>
<td>(10) Are there physician protections for professional standards and ethics?</td>
<td>Yes 47.30.956</td>
<td>Yes, so long as physician makes a good faith attempt to transfer patient 327F-9, 327F-13</td>
<td>Yes 66-611</td>
<td>Yes 43/33</td>
<td>Yes, so long as physician makes a good faith attempt to transfer patient 1101(11), 1101(15)</td>
<td>Yes 213B.09(3)(f)</td>
</tr>
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</tr>
<tr>
<td>North Carolina</td>
<td>No</td>
<td>Yes</td>
<td>Two persons, physicians or psychologists</td>
<td>&quot;A person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person cannot currently make mental health treatment decisions...&quot;</td>
<td>a. physician b. eligible psychologist</td>
<td>Yes</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>No</td>
<td>Yes</td>
<td>11-106(E)</td>
<td>&quot;A person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person cannot currently make mental health treatment decisions...&quot;</td>
<td>a. physician b. eligible psychologist</td>
<td>Yes</td>
</tr>
<tr>
<td>Oregon</td>
<td>No</td>
<td>Yes</td>
<td>127.761-127.765</td>
<td>&quot;The condition of a person whose ability to receive and evaluate information effectively is impaired to such an extent that the person cannot currently make mental health treatment decisions...&quot;</td>
<td>a. physician b. eligible psychologist</td>
<td>Yes</td>
</tr>
<tr>
<td>South Dakota</td>
<td>No</td>
<td>Yes</td>
<td>27A-16-18</td>
<td>&quot;A person lacks the ability to understand the nature and consequences of proposed treatment, including the benefits, risks, and alternatives, lacks ability to make mental health treatment decisions because of impairment...&quot;</td>
<td>a. physician b. eligible psychologist</td>
<td>Yes</td>
</tr>
<tr>
<td>Texas</td>
<td>No</td>
<td>Yes</td>
<td>32A-12-000</td>
<td>&quot;A person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person cannot currently make mental health treatment decisions...&quot;</td>
<td>a. physician b. eligible psychologist</td>
<td>Yes</td>
</tr>
<tr>
<td>Utah</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>&quot;A person lacks the ability to understand the nature and consequences of proposed treatment, including the benefits, risks, and alternatives, lacks ability to make mental health treatment decisions because of impairment...&quot;</td>
<td>a. physician b. eligible psychologist</td>
<td>Yes</td>
</tr>
</tbody>
</table>

1 The 1998 amendments (effective 10/1/98) attempt to clarify the relationship between the state's general health care directive provisions in 32A-63 and the "Advanced Medical Directives" in 122C. The latter sections are an "additional, nonexclusive method" for issuing a mental health care directive. Both are valid. However, if a person makes two conflicting mental health treatment directives, the directions made pursuant to 122C will prevail.
2 The Oregon provision also requires all health care and mental health care organizations to maintain policies and provide advance directive information to patients.
3 This provision allows the doctor to proceed as guardian.
### ADVANCE MEDICAL DIRECTIVES & MENTAL HEALTH TREATMENT

<table>
<thead>
<tr>
<th>STATE</th>
<th>STATUTE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alabama</strong></td>
<td></td>
<td><strong>Alabama</strong> A Code of Ala. § 22-8A-4 Advance directive. B Code of Ala. § 26-1-2. Durable power of attorney. A. Does not apply to mental health treatment (MHT). B. Specifically precludes designated attorney from making mental health treatment decisions. Attorney cannot make decisions re: “psychosurgery... or involuntary hospitalization or treatment covered by Subtitle 2 of Title 22 [Health, Mental Health and Environmental Control].”</td>
</tr>
<tr>
<td><strong>Alaska</strong></td>
<td>AS 47.30.950 - 47.30.980 Declaration for mental health treatment</td>
<td></td>
</tr>
<tr>
<td><strong>Arizona</strong></td>
<td>A. R.S. § 36-3201 to 3262 Living wills and health care directives</td>
<td>A. Provisions allow for broad-based health care decisions and likely do cover MHT, except for prehospital medical care directives. B. “An agent’s authority to make health care decisions on behalf of the principal is limited only by the express language of the health care power of attorney or by court order as prescribed under section 36-3266.” C. Does not apply to MHT.</td>
</tr>
<tr>
<td><strong>Arkansas</strong></td>
<td>§ 20-17-202. Declaration relating to use of life-sustaining treatment.</td>
<td>Does not apply to MHT.</td>
</tr>
<tr>
<td><strong>California</strong></td>
<td>Cal Prob Code § 4700 et seq. Durable powers of attorney for health care</td>
<td>Limited use for MHT, arguably can be used for psychotropic medication. § 4722. “A power of attorney may not authorize the attorney-in-fact to consent to any of the following on behalf of the principal: (a) Commitment to or placement in a mental health treatment facility. (b) Convulsive treatment (as defined in Section 5325 of the Welfare and Institutions Code). (c) Psychosurgery (as defined in Section 5325 of the Welfare and Institutions Code).”</td>
</tr>
<tr>
<td><strong>Yes, however, limited.</strong></td>
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</tbody>
</table>
### ADVANCE MEDICAL DIRECTIVES & MENTAL HEALTH TREATMENT

<table>
<thead>
<tr>
<th>State</th>
<th>Code Reference</th>
<th>Medical Treatment Authority</th>
<th>Mental Health Treatment Authority</th>
</tr>
</thead>
</table>
| **Colorado** | a. C.R.S. 15-14-506  
Yes, however, not explicit. | a. Can include directive for MHT. | b. Applies only to life-sustaining procedures. |
|             | b. C.R.S. 15-18-104  
Medical durable powers of attorney | | |
|             | c. C.R.S. 15-14-501  
Declaration as to medical treatment | | |
|             | a. Can include directive for MHT. | | |
|             | b. Applies only to life-sustaining procedures. | | |
|             | c. Power of attorney granting medical treatment authority executed prior to July 1, 1992 | | |
| **Connecticut** | Conn. Gen. Stat. § 1-54a  
Power of Attorney, See also Conn. Gen. Stat. § 1-43 | Designated agent can make any medical care decisions. Appears to allow limiting instructions. | |
| **Delaware** | 16 Del. C. § 2503  
Advance health-care directives | Allows person to give individual instruction and/or execute power of attorney for any health care decisions. | |
| **D.C.** | D.C. Code § 21-2205. Durable power of attorney for health care | Specifically applies to "mentally ill." | |
| **Florida** | a. Fla. Stat. § 765.101 et seq.  
Health care advance directives | a. Can include specific health care instructions, the designation of a health care surrogate, a living will, and orders not to resuscitate. | |
Health care surrogate | b. "A principal may designate a separate surrogate to consent to mental health treatment...However, unless the document designating the health care surrogate expressly states otherwise, the court shall assume that the health care surrogate authorized to make health care decisions under this chapter is also the principal's choice to make decisions regarding mental health treatment." | |
| **Georgia** | a. O.C.G.A. § 31-32-3  
Living wills | a. Applies only to life-sustaining procedures. | |
|             | b. O.C.G.A. § 31-36-4  
Durable power of attorney for health care | b. Agent authorized to make all health care decisions. | |
| **Hawaii** | HRS § 327F-3  
Medical treatment decisions for psychotic disorders | | |
| **Idaho** | Idaho Code § 66-602. Declarations for mental health treatment | | |
| **Illinois** | § 755 ILCS 43/01 to 43/115  
Mental Health Treatment Preference Declaration Act | | |
### ADVANCE MEDICAL DIRECTIVES & MENTAL HEALTH TREATMENT

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<thead>
<tr>
<th>State</th>
<th>Yes/No</th>
<th>Section(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td>No</td>
<td>a. Burns Ind. Code Ann. § 30-5-3-16 to § 30-5-5-17 Powers of attorney</td>
<td>a. Does not apply to MHT, applies only to treatment decisions covered by § 16-36-4-8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Burns Ind. Code Ann. § 16-36-4-8 Life prolonging procedures will</td>
<td>b. Does not apply to MHT.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>declaration or living will declaration</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>No, however, a durable power of attorney for health care allows agent to</td>
<td>a. Includes all health care decisions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>make MHT decisions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Iowa Code § 144B.1 et seq. Durable power of attorney for health care</td>
<td>b. Does not apply to MHT.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. 144A.3 Declaration relating to use of life-sustaining procedures</td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>Yes.</td>
<td>K.S.A. § 38-632 Durable power of attorney for health care</td>
<td>Can include appointment of agent and specific instructions for all health care decisions.</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Yes, however, not explicit.</td>
<td>a. KRS 311.623, see also KRS 311.621 to 311.643 Living Will Directive Act</td>
<td>Can include appointment of agent and advance directive for health care decisions.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>No</td>
<td>La. R.S. 40:1299.38.1 Declarations Concerning Life-sustaining Procedures</td>
<td>Does not cover MHT.</td>
</tr>
<tr>
<td>Maine</td>
<td>Yes</td>
<td>a. 34-B M.R.S. § 1101 Medical Treatment of Psychotic Disorders</td>
<td>a. Specifically addresses MHT.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. 18-A M.R.S. § 5-802 Advance health-care directives</td>
<td>b. Can give instructions for all health care decisions.</td>
</tr>
<tr>
<td>Maryland</td>
<td>Yes, however, not explicit.</td>
<td>Md. HEALTH-GENERAL Code Ann. § 5-601 et seq. Health Care Decision Act</td>
<td>Includes advance directive for any health care decisions.</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Yes, however, not explicit.</td>
<td>Mass. Ann. Laws ch. 201D, § 1 Health Care Proxies</td>
<td>Proxy can include specific instructions limiting authority of designated agent.</td>
</tr>
<tr>
<td>Michigan</td>
<td>Yes, however, not explicit.</td>
<td>MSA § 27.5496, Designation of patient advocate</td>
<td>Designates agent and allows specific instructions for health care.</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Yes</td>
<td>a. Minn. Stat. § 253B.03 subd. 6b-d Consent for intrusive mental health</td>
<td>a &quot;intrusive mental health treatment&quot; means electroshock therapy and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>treatment means neuroleptic medication</td>
<td>b. Includes nonintrusive MHT only, unless the durable power of attorney for health care specifically applies to decisions relating to intrusive mental health treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Minn. Stat. § 145C.01 et seq.</td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>Yes, however, not explicit.</td>
<td>Miss. Code Ann. § 41-41-205 The Uniform Health-Care Decisions Act</td>
<td>Includes all forms of health care.</td>
</tr>
<tr>
<td>Missouri</td>
<td>Yes, however, not explicit in statute.</td>
<td>a. § 404.710. R.S.Mo. Power of attorney with general powers</td>
<td>a. Designated attorney has power to &quot;give consent to or prohibit any type of health care, medical care, treatment or procedure to the extent</td>
</tr>
</tbody>
</table>
## ADVANCE MEDICAL DIRECTIVES & MENTAL HEALTH TREATMENT

<table>
<thead>
<tr>
<th>State</th>
<th>Declaration relating to use of life-sustaining treatment</th>
<th>Statutory form of power of attorney</th>
<th>Allows for instructions and appointment of agent to make any health care decisions.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nebraska</strong></td>
<td>R.R.S. Neb. § 30-3401 to 30-3432</td>
<td>Allows for instructions and appointment of agent to make any health care decisions.</td>
<td></td>
</tr>
<tr>
<td><strong>Nevada</strong></td>
<td>Nev. Rev. Stat. Ann. § 449.800 to 449.860</td>
<td>Allows for agent designation and instructions. Health care decisions may include &quot;consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.&quot;</td>
<td></td>
</tr>
<tr>
<td><strong>New Hampshire</strong></td>
<td>R.S.A. 137-J:2 Durable Power of Attorney for Health Care</td>
<td>Allows for agent designation and instructions. Agent has &quot;authority to make any and all health care decisions...&quot; However, the agent may not &quot;consent to voluntary admission to any state institution.&quot;</td>
<td></td>
</tr>
<tr>
<td><strong>New Jersey</strong></td>
<td>N.J. Stat. § 26:21H-53 et seq. New Jersey Advance Directives for Health Care Act</td>
<td>&quot;Health care decision&quot; means a decision to accept or to refuse any treatment, service or procedure used to diagnose, treat or care for a patient's physical or mental condition, including life-sustaining treatment.</td>
<td></td>
</tr>
</tbody>
</table>
## ADVANCE MEDICAL DIRECTIVES & MENTAL HEALTH TREATMENT

<table>
<thead>
<tr>
<th>State</th>
<th>Yes/No</th>
<th>Statute/Code</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico</td>
<td>Yes</td>
<td>N.M. Stat. Ann. § 24-7A-1 et seq. Uniform Health-Care Decisions</td>
<td>Allows specific health care instructions and agent designation. &quot;Health care&quot; means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.</td>
</tr>
<tr>
<td>New York</td>
<td>Yes</td>
<td>NY CLS Pub Health § 2980 et seq. Health Care Proxies and Agents</td>
<td>The health care proxy designates an agent. It may also include the principal's wishes or instructions about health care decisions, and limitations upon the agent's authority. &quot;Health care&quot; means any treatment, service or procedure to diagnose or treat an individual's physical or mental condition.</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Yes</td>
<td>N.C. Gen. Stat. § 122C-71 et seq. Advance Instruction for Mental Health Treatment</td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>Yes, however, not explicit. Also limited.</td>
<td>N.D. Cent. Code, § 23-06.5-03 Durable Power of Attorney for Health Care</td>
<td>&quot;Subject to the provisions of this chapter and any express limitations...the agent has the authority to make any and all health care decisions...&quot; &quot;Nothing in this chapter permits an agent to consent to admission to a mental health facility or state institution for a period of more than forty-five days without a mental health proceeding or other court order, or to psychosurgery, abortion, or sterilization, unless the procedure is first approved by court order.&quot;</td>
</tr>
<tr>
<td>Ohio</td>
<td>Yes</td>
<td>ORC Ann. 1337.11 et seq. Power of Attorney [Durable Power for Health Care]</td>
<td>Allows agent designation and instructions. &quot;Health care&quot; means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Yes</td>
<td>43A Okl. St. § 11-101 et seq. Advance Directives for Mental Health Treatment Act</td>
<td></td>
</tr>
</tbody>
</table>
| Oregon              | Yes    | a. ORS § 127.500 et seq. Declarations for mental health treatment b. ORS § 127.505 to § 127.660 and § 127.995 Powers of Attorney: Advance directives for health care | a. Specific declaration for MHT, separate and distinct from general powers of attorney provisions. b. Note that the general powers of attorney provisions do not cover MHT. ORS § 127.505 to § 127.660 and § 127.995 "do not authorize an appointed health care representative
<table>
<thead>
<tr>
<th>State</th>
<th>Section/Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania</td>
<td>No</td>
<td>20 Pa.C.S. § 5401 et seq. Advance directive for health care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does not cover MHT, only &quot;the initiation, continuation, withholding or withdrawal of life-sustaining treatment...&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.&quot;</td>
</tr>
<tr>
<td>South Carolina</td>
<td>No, however, an agent can be appointed to make MHT decisions.</td>
<td>a. S.C. Code Ann. § 62-5-501 et seq. Powers of Attorney</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is no mention of an advance directive or limiting instructions in either provision.</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Yes</td>
<td>S.D. Codified Laws § 27A-16-1 et seq. Mental Illness Treatment Decisions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Can include directive for any type of medical care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Tenn. Code Ann. § 34-6-201 et seq. Durable Power of Attorney for Health Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Can include limiting instructions. &quot;Health care&quot; means any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental condition...</td>
</tr>
<tr>
<td>Texas</td>
<td>Yes</td>
<td>Tex. Civ. Prac. &amp; Rem. Code § 137.001 et seq. Declaration for Mental Health Treatment</td>
</tr>
<tr>
<td>State</td>
<td>Yes</td>
<td>Statutory Authority</td>
</tr>
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</tr>
<tr>
<td>Utah</td>
<td></td>
<td>Utah Code Ann. § 62A-12-501 et seq. Declaration for Mental Health Treatment</td>
</tr>
</tbody>
</table>
| Vermont|     | Note: both sections apply. § 7626 specifically applies the earlier section to psychiatric treatment. a. 14 V.S.A. § 3451 et seq. Durable powers of attorney for health care b. 18 V.S.A. § 7626 Durable power of attorney | a. § 3453 The agent’s authority is in effect “only when the principal lacks capacity to make health care decisions, as certified in writing by the principal’s attending physician...” When the durable power of attorney is in effect and “irrespective of the principal’s capacity...treatment may not be given to or withheld from the principal over the principal’s objection.” b. § 7626 (a) If a person is the subject of a petition for involuntary medication and has executed a durable power of attorney, “the court shall suspend the hearing on the petition, and enter an order for treatment, if the court determines that: (1) the person is refusing to accept psychiatric medication; (2) the person is not competent to make a decision regarding the proposed treatment; and (3) the decision regarding the proposed treatment is within the scope of the valid, duly executed durable power of attorney for health care... § 7626 (c) The court shall reconvene
<table>
<thead>
<tr>
<th>State</th>
<th>Advance Directive or Agent Designation</th>
<th>Potential Limitations</th>
</tr>
</thead>
</table>
b. "A guardian's duties and authority shall not extend to decisions addressed in a valid advance directive or durable power of attorney..." |
| Washington | Rev. Code Wash. § 11.94.010 et seq. Power of Attorney | "A principal may authorize his or her attorney-in-fact to provide informed consent for health care decisions on the principal's behalf." |
However, "A health care agent may not consent to admission of the principal on an inpatient basis to any of the following...An institution for mental diseases...A state treatment facility..." Additionally, "A health care agent may not consent to experimental mental health research or to psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for the principal." |
| Wyoming    | Wyo. Stat. § 3-5-201 et seq. Power of Attorney for Health Care | "A durable power of attorney for health care shall not authorize the attorney in fact to consent to any of the following on behalf of the principal:  
(i) Commitment to or placement in a mental health treatment facility;  
(ii) Convulsive treatment; or  
(iii) Psychosurgery." |