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AN AMERICANS WITH DISABILITIES ACT
CRITIQUE OF ADVANCE DIRECTIVE
OVERRIDE PROVISIONS

JUDY ANN CLAUSEN*

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* Associate Professor of Law, Florida Coastal School of Law, B.A.,
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There can be no doubt that all patients, including patients with severe mental illness, have the right to participate meaningfully in the course of their treatment, to be free from unnecessary or unwanted medication, and to have their rights of personal autonomy and bodily integrity respected by agents of the state.¹

INTRODUCTION

Advance directives empower people to determine the care that may be administered when they lack the capacity to provide informed consent.² General advance directives (generic directives) typically address end-of-life care, but mental health advance directives (mental health directives) govern treatment administered during periods of incapacity caused by acute mental illness episodes.³ Because end-of-life decision making implicates different issues than planning for episodic mental illness, half of the states have enacted separate mental health directive statutes.⁴ The majority of these

³. Patricia Backlar, Anticipatory Planning for Psychiatric Treatment Is Not Quite the Same as Planning for End-of-Life Care, 33 Community Mental Health J. 261, 262 (1997).
specialized statutes make it easier for a doctor to override a mental health directive than do their counterpart generic directive statutes.\footnote{5}

One example of a typical generic directive statute, the Uniform Health-Care Decisions Act (Uniform Act), allows doctors to override a generic directive for reasons of conscience or if the requested treatment is medically ineffective or contrary to generally accepted health-care standards.\footnote{6} When the institution does not comply with the directive, it must inform the patient, make reasonable efforts to assist in transferring the patient to another institution willing to comply with the directive, and provide continuing care until transfer.\footnote{7}

\footnote{5. VHA Report, supra note 4, at 6 (asserting seventeen of the twenty-five states with specialized statutes currently give clinicians greater leeway to abrogate a mental health directive than they have to abrogate a generic one); Making the Most of Psychiatric Advance Directives, supra note 4, at 3 (“[M]ost state laws give clinicians broad discretion to override a psychiatric advanced directive.”); Karl A. Menninger, II, \textit{Advance Directives for Medical & Psychiatric Care} § 27, 102 Am. Jur. Proof of Facts 3d 95 (last updated Dec. 2015) (listing the standard reasons physicians may override a mental health directive which are more expansive than authority to override a generic directive); \textit{see, e.g.}, N.J. Stat. Ann. § 26:2H-105 (2012) (mental health directive statute allowing directive abrogation when compliance would violate the accepted standard of care, require the use of unavailable care, violate a court order or legal provision, or endanger the life or health of the patient or another); N. J. Stat. Ann. § 26:2H-62 (2012) (generic directive statute allowing generic directive abrogation for reasons of conscience, but facility must make efforts to transfer to a facility willing to comply with the directive); \textit{cf.} Justine A. Dunlap, \textit{Mental Health Advance Directives: Having One’s Say?}, 89 Ky. L. J. 327, 361 (2001) (exploring circumstances that justify overriding a mental health directive and stating: “[P]arents patriae authority is often invoked to prevent harm to persons who, while competent, have chosen a course that will probably—or perhaps inexorably—result in harm. This dichotomy is one example of how mental health-care decisions are treated differently. Persons with physical illnesses are allowed to make choices that will end in death but persons with mental illness often are not allowed to make decisions with results less severe.”).


\footnote{7. \textit{Id.}}}
Mental health directive statutes often provide doctors more leeway to force treatment on a patient.\(^8\) Many of these statutes authorize directive abrogation in emergencies (typically not defined), pursuant to court order (without setting forth criteria for issuance of such orders), or in the commitment context (sometimes without further limitation).\(^9\) Generally, they do not require the institution to transfer the patient to a facility willing to honor the mental health directive. The typical generic directive statute allows doctors to decline to administer inappropriate treatments, whereas the typical mental health directive statute authorizes doctors to impose treatment on patients in certain circumstances.\(^10\)

This Article argues that many mental health directive override provisions violate the Americans with Disabilities Act (ADA).\(^11\) It proposes a model override provision that complies with the ADA and allows doctors flexibility to respond to threats to the patient’s life or the health or safety of others.\(^12\) Part I.A gives the reader an overview of advance directives. It defines an override provision as a statutory provision allowing doctors to abrogate the patient’s directive in certain situations.\(^13\) Part I.A also explores the common ground as well as the key differences between generic and mental health directives.

Part I.B lays out the framework for an ADA challenge to a statutory scheme that gives doctors greater leeway to override a mental health directive than a generic one. Title II of the ADA states that

\(^8\) See infra note 9 and accompanying text.

\(^9\) VHA REPORT, supra note 4, at 6; see, e.g., OR. REV. STAT. § 127.720 (2012) (authorizing directive abrogation in the commitment context and in cases of emergencies endangering life or health); TENN. CODE ANN. § 33-6-1006 (2012) (authorizing directive abrogation if the person is committed and a treatment review committee authorized treatment or there is an emergency endangering the patient’s life or health); TEX. CIV. PRAC. & REM. CODE ANN. § 137.008 (West 2015) (authorizing directive abrogation if the person is under order for temporary or extended mental health services and treatment is authorized pursuant to statute, or, in cases of emergencies, in which the patient’s instructions have not been effective in reducing the severity of the behavior that caused the emergency); UTAH CODE § 62A-15-1003 (2012) (authorizing directive abrogation in cases in which the principal has been committed or, in cases of emergencies, endangering life or health).

\(^10\) VHA REPORT, supra note 4, at 6.

\(^11\) See infra Part II.B.

\(^12\) See infra Part III.A.

\(^13\) VHA REPORT, supra note 4, at 6; see, e.g., UNIF. HEALTH-CARE DECISIONS ACT § 7(e)–(f), 9 U.L.A. 27–28 (2012); Jeffrey W. Swanson et al., Overriding Psychiatric Advance Directives: Factors Associated with Psychiatrists’ Decisions to Preempt Patients’ Advance Refusal of Hospitalization and Medication, 31 LAW & HUM. BEHAV. 77, 77 (2007) [hereinafter Swanson, Overriding].
no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity.14 As explored in Part I.B, people with mental illnesses who form mental health directives are qualified individuals with a disability under the ADA.15 When a state makes it easier for a doctor to override mental health directives than generic directives, the state discriminates against people with mental illness due to their disability.16

The ADA’s direct threat exception allows public entities to prevent an individual from participating in or benefiting from services or programs where the individual poses a direct threat to the health or safety of others.17 A statutory scheme that gives more expansive override authority only in the mental health context is not exempt from the antidiscrimination mandate of the ADA unless an exception like the direct threat exception applies.18 Part II.B illustrates that many mental health directive statutes authorizing directive abrogation in emergencies, by court order, or in the commitment context do not fall within the direct threat exception to the nondiscrimination mandate of the ADA. The ADA implementing regulations require that public entities seeking to invoke the direct threat exception make an individualized assessment of whether the individual poses a direct threat to the health or safety of others based on current medical knowledge or the best available objective evidence.19 Part II.B.3 shows that many mental health directive statutes allowing doctors to override a directive in the commitment context, without further limitation, fail to require an individualized dangerousness assessment at the time of directive abrogation, as required by the ADA.20 Even if the committing court determined that the person was dangerous at the time of initial commitment, after a

15. 29 C.F.R. § 1630.2(h)(2) (2012) (disability includes “[a]ny mental or psychological disorder, such as . . . emotional or mental illness”); Hargrave v. Vermont, 340 F.3d 27, 36 (2d Cir. 2003).
18. 42 U.S.C. § 12182(b)(3); see also Hargrave, 340 F.3d at 37 (finding that a Vermont law violated the ADA by distinguishing between patients incapacitated by mental illness and those otherwise incapacitated).
19. 28 C.F.R. § 35.139 (2012) (direct threat exception to nondiscrimination mandate on the basis of disability in state and local governmental services); see also Velez, 974 F. Supp. 2d at 732.
20. 28 C.F.R. § 35.139; Hargrave, 340 F.3d at 36.
period of hospitalization and treatment, the person may no longer pose a direct threat to the health or safety of others.\textsuperscript{21}

Similarly, Part II.B.1 argues that authorizing a doctor to override a mental health directive in unspecified emergencies potentially violates the ADA.\textsuperscript{22} Without clarification, such emergencies arguably encompass acute mental health episodes that do not endanger the health or safety of the patient or others. If emergencies are defined this broadly, many acute episodes would automatically be considered emergencies because, if left untreated, these episodes could lead to deterioration of the patient’s cognitive functions.\textsuperscript{23} If such acute episodes were emergencies, doctors could force treatment in situations where a patient is not a direct threat to her own life or to the health or safety of others, and is not subject to forced medication under commitment laws which typically require an assessment of the patient’s dangerousness to self or others.\textsuperscript{24} Such situations do not fall under the direct threat exception in the ADA.\textsuperscript{25} Allowing directive abrogation in such situations violates the ADA and applicable commitment laws.\textsuperscript{26}

Finally, Part II.B.2 posits that authorizing doctors to override mental health directives pursuant to court order, without further guidance, is overly broad and does not comply with the ADA’s direct threat exception. Allowing directive abrogation pursuant to court order, without providing guidance as to the criteria for issuing such orders or as to the timeliness of the order in relation to the directive contravention, does not ensure an individualized dangerousness assessment at the time of directive abrogation, as is required by the ADA.\textsuperscript{27}

Part III articulates a model override provision for states to adopt. Part III.A analyzes two other recommended override provisions, one from the National Ethics Committee of the Veterans Health Administration (VHA Committee) and one from Professor

\textsuperscript{21} Hargrave, 340 F.3d at 36.
\textsuperscript{22} VHA REPORT, \textit{supra} note 4, at 6; \textit{see infra} Part II.B.1.
\textsuperscript{24} 42 U.S.C. § 12182(b)(3) (2012).
\textsuperscript{25} \textit{Id.}
\textsuperscript{26} Hargrave, 340 F.3d at 36.
\textsuperscript{27} \textit{See infra} Part II.B.2.
Bruce Winick. The VHA Committee’s approach, adopting the typical generic directive override provision in the mental health context, fails to grant doctors the flexibility to respond to emergencies endangering the patient’s life or the health or safety of others. Professor Winick’s approach allows directive abrogation in the police power commitment context but not in the parens patriae commitment context. This proposal focuses on the wrong issue, the basis for commitment, and fails to require an individualized dangerousness assessment at the time of directive abrogation. Part III.B provides this Article’s model approach, which complies with the ADA, clarifies the interaction between mental health directive laws and commitment laws, and effectively balances patients’ autonomy rights with the state’s interest in protecting human safety. For all forms of directives, it adopts the Uniform Act’s override provision and adds another override authority, allowing doctors to contravene a directive when following the directive would pose a direct threat to the health or safety of others or when a mental health emergency directly threatens the patient’s life. Situations threatening the health and safety of others could include mental health emergencies as well as other situations, such as instances in which a contagious tuberculosis patient refuses treatment and quarantine in her directive. The recommended approach is ADA compliant, since it tracks the language of the direct threat exception.

I. BACKGROUND ON ADVANCE DIRECTIVES AND THE ADA

This Part provides background on advance directives and the ADA. Part I.A sets forth an advance directives primer. It defines an override provision and explores the common ground and key differences between generic and mental health directives. Part I.B lays out the framework for an ADA challenge to a mental health


29. VHA Report, supra note 4, at 7.


31. See infra Part III.B.


33. See infra Part III.B.


directive statute that provides clinicians greater authority to abrogate a mental health directive than a generic one.\footnote{36}

A. Advance Directives Primer

1. Override Provision Defined

Modern informed consent law requires doctors to provide patients with relevant information about the risks and benefits of any proposed treatment and to obtain the patient’s informed consent before administering treatment.\footnote{37} To give valid informed consent, the patient must be capable of making a knowing and voluntary decision concerning treatment.\footnote{38} For a treatment decision to be knowing and voluntary, the patient must have capacity.\footnote{39} Advance directive statutes typically define capacity as the ability to make and communicate health-care decisions and understand the significant benefits, risks, and alternatives to proposed treatment.\footnote{40}

Clinicians who render treatment without informed consent are subject to liability for various torts, including independent causes of action for lack of informed consent, assault, battery, negligence, and false imprisonment,\footnote{41} and for various statutory violations.\footnote{42} For example, in Florida, admitting an incapacitated patient under vol-

\footnote{36. \textit{See infra} Part I.B.}
\footnote{38. \textit{See infra} note 434.}
\footnote{39. \textit{See, e.g.}, \textit{FLA. STAT. § 765.101} (10)–(11) (West 2015) (defining incapacity to mean that the patient is unable to communicate a willful and knowing health-care decision, and defining informed consent as consent voluntarily given by a patient after sufficient explanation and disclosure of risks and alternatives to make a knowing health-care decision).}
\footnote{40. \textit{See, e.g.}, \textit{UNIF. HEALTH-CARE DECISIONS ACT} § 1(3), 9 U.L.A. 3 (2012).}
\footnote{42. \textit{See, e.g.}, \textit{FLA. STAT. § 765.101} (10)–(11) (prohibiting voluntary admission of mental health incapacitated patients).}
untary admission procedures violates Florida’s Mental Health Act.\textsuperscript{43} In state-operated facilities, rendering treatment without obtaining the patient’s valid informed consent potentially subjects the facility and clinicians to liability for due process violations under 42 U.S.C. § 1983.\textsuperscript{44}

When injury or illness disrupts the patient’s capacity, an advance directive enables the patient to provide informed consent in advance so doctors may administer care.\textsuperscript{45} Statutes regulating advance directives require doctors to follow the treatment preferences articulated in a directive, except in narrowly defined circumstances. These override provisions allow doctors to abrogate the patient’s directive in certain situations, thereby shielding clinicians from liability when they contravene directives, so long as they do so within the parameters of the override provision.\textsuperscript{46}

2. Generic and Mental Health Directives: The Common Ground

The primary purpose of both generic and mental health directives is to support patient self-determination by empowering patients to exercise control over treatment administered when illness has destroyed capacity. Both generic and mental health directives come in various forms.\textsuperscript{47} Instructional directives enable a patient to specify treatment to be administered when the patient is incapacitated.\textsuperscript{48} In the end-of-life context, an instructional directive might state, “If I am in a permanent vegetative state, I do not want doctors to administer artificial hydration and nutrition.”\textsuperscript{49} In the mental health context, an instructional directive might state, “If an episode destroys my capacity, I consent to antipsychotic medication.”\textsuperscript{50}

Proxy directives, otherwise known as durable powers of attorney, allow patients, also known as principals, to appoint trusted representatives or agents to make health-care decisions for them.\textsuperscript{51} In both the end-of-life and mental health contexts, clinicians often recommend hybrid directives, which enable patients to give instructions and designate agents.\textsuperscript{52} Arguably, the hybrid directive best

\begin{footnotesize}
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\item \textsuperscript{43} \textit{Fla. Stat.} § 394.459(8)(b) (2012).
\item \textsuperscript{44} \textit{Zinermon v. Burch}, 494 U.S. 113, 113 (1990).
\item \textsuperscript{45} See \textit{La Fond & Srebnik}, supra note 2, at 537–40; see also \textit{Fla. Stat.} § 765.102(2) (West 2015).
\item \textsuperscript{46} \textit{VHA REPORT}, supra note 4, at 6; \textit{Dunlap}, supra note 5, at 371.
\item \textsuperscript{47} \textit{Dunlap}, supra note 5, at 347–51.
\item \textsuperscript{48} \textit{La Fond & Srebnik}, supra note 2, at 540.
\item \textsuperscript{49} \textit{Backlar}, supra note 3, at 262.
\item \textsuperscript{50} \textit{Id.}
\item \textsuperscript{51} \textit{La Fond & Srebnik}, supra note 2, at 541.
\item \textsuperscript{52} \textit{102 Am. Jur. 3d 95 Proof of Facts §§ 7, 25} (2008).
\end{itemize}
\end{footnotesize}
supports patient self-determination, because it enables the patient to give guidance to her doctors and her agent.\textsuperscript{53} No directive can address every situation that may arise during the chaos caused by a terminal illness or an acute mental illness episode. Even in an unforeseen situation, the hybrid directive allows the patient to exercise control over her care through her agent.\textsuperscript{54}

3. Differences Between Generic and Mental Health Directives

Whereas a patient seeks to secure a dignified death through a generic directive, a patient strives to obtain a stable life or avoid unwanted side effects through a mental health directive.\textsuperscript{55} Because end-of-life decision making is different than planning for episodic mental illness, half of the states have enacted separate mental health directive statutes.\textsuperscript{56} This Section explains how the end-of-life and episodic mental illness contexts are distinct and identifies key differences between generic and mental health directive statutes.\textsuperscript{57} This comparison enables the reader to appreciate why states often craft more expansive override provisions for mental health directives than for generic ones.\textsuperscript{58}

a. The Commitment Context and Illness-Induced Treatment Refusal

The interaction of mental health directive laws with commitment laws is unclear.\textsuperscript{59} For example, in many states the agent named in the mental health directive "is not authorized to place the principal in a locked mental health facility, to coerce the principal to take psychotropic medication against [her] will, or to subject the principal to electroconvulsive therapy."\textsuperscript{60} Forced hospitalization and treatment to prevent dangerousness are implicated in the

\textsuperscript{53} Winick, \textit{Advance Directive Instruments}, supra note 28, at 82; Dunlap, supra note 5, at 348 (asserting that a hybrid directive may be the most effective way to protect patient wishes).

\textsuperscript{54} Dunlap, supra note 5, at 348–49.

\textsuperscript{55} Backlar, supra note 3, at 263.

\textsuperscript{56} See supra note 5 and accompanying text.

\textsuperscript{57} See infra Part I.A.3.

\textsuperscript{58} See VHA Report, supra note 4, at 6.

\textsuperscript{59} A. Kimberley Dayton et al., \textit{Advising the Elderly Client}, § 33:18 (2015).

mental health arena, not in the end-of-life context. This is because mental illness can prevent a patient from recognizing that she is sick and cause her to refuse treatment to which she would otherwise consent. This phenomenon is known as an illness-induced treatment refusal. Once a mental health episode induces a person to refuse intervention, the primary means of administering treatment is through involuntary commitment.

A basic summary of involuntary commitment law is necessary to appreciate why the interaction between mental health directive laws and commitment laws is vague. The state’s authority to commit people with mental illness derives from two components of state sovereignty. The first is the police power, which is the authority to maintain peace and order. States define this as the authority to confine a person who is likely to be dangerous to others. The second is the parens patriae power, which enables the state to protect a person whose mental illness makes her likely to harm herself or prevents her from being able to care for her basic needs.

The Supreme Court has held that civil commitment imposes a massive curtailment of liberty, necessitating strict commitment criteria. The clear and convincing evidence standard meets due process guarantees for civil commitment proceedings, while the preponderance of the evidence standard is not adequate in this context. For police power commitment, states typically require the government to show that, because of mental illness, the person

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62. See Kay Redfield Jamison, An Unquiet Mind: A Memoir of Moods and Madness 36 (1995); Davoli, supra note 23, at 1009 (asserting that the inability to accept that one is mentally ill is a symptom of mental illness); VHA Report, supra note 4, at 8 (stating patients entering a mania may not recognize that they are manic and refuse treatment).


64. Id. at 415.

65. See Dayton et al., supra note 59, at § 33:18.

66. Addington v. Texas, 441 U.S. 418, 426 (1979); Clausen, supra note 41, at 9 (providing explanation of commitment law).

67. Clausen, supra note 41, at 9.

68. Id.

69. Id.


71. Addington, 441 U.S. at 432–33.
is a danger to others. First, the state must prove that the person suffers from a mental illness or disorder, often defined as a substantial disorder of emotional processes, thought, or cognition that grossly impairs judgment, behavior, or capacity to recognize reality. Second, most states require proof that mental illness caused the dangerousness. Third, the government must prove dangerousness itself, often defined as a substantial likelihood that, in the near future, the person will inflict serious bodily harm on another, as evidenced by recent behavior. Many jurisdictions demand a finding of an overt act as a prerequisite to involuntary commitment.

For parens patriae commitment, states generally require the government to prove mental illness caused the person to be a danger to herself or rendered her unable to provide for her basic needs. States that have an overt act requirement for police power commitment also have such a requirement for parens patriae commitment. For both types of commitment, almost all states require consideration of less restrictive alternatives to involuntary hospitalization that allow for care and prevent danger, such as outpatient treatment, day or night treatment in a hospital, placement in the custody of a loved one, or home health services.

Generally, states authorize involuntary emergency admission and evaluation without a full adjudicatory hearing. Typically, states authorize police to detain and transport a person to a hospital when the officer concludes she meets emergency detention and screening criteria, which is essentially the same standard as for commitment. At the facility, a doctor examines the person to determine if emergency treatment is necessary to protect the safety of

74. Slobogin et al., supra note 72, at 726.
75. Fla. Stat. § 394.467(1)(b) (2012); In re B.T., 891 A.2d 1193, 1198 (N.H. 2006); Coyle, supra note 41, at § 4.
77. Slobogin et al., supra note 72, at 705.
79. But see Fla. Stat. § 394.467(1)(b) (2012); Haw. Rev. Stat. § 334-60.2 (2012) (neither Hawaii nor Florida require a finding that all available less restrictive treatment alternatives were adjudged inappropriate); Randolph v. Cervantes, 950 F. Supp. 771, 777 (S.D. Miss. 1996); Slobogin et al., supra note 72, at 782.
80. Hermann, supra note 78, at 165.
81. See, e.g., Fla. Stat., § 394.463(2)(f); Coyle, supra note 41, at § 2.
the person or others.\footnote{See, e.g., Fla. Stat. § 394.463(2)(f).} States impose strict time limits under which a person may be subject to involuntary admission and examination.\footnote{Slobogin et al., supra note 72, at 811; see, e.g., Va. Code Ann. § 37.2-809 (stating that the “duration of temporary detention . . . shall not exceed 72 hours before there is a hearing”).} For example, in Florida, a clinician must examine a person to determine if she meets involuntary commitment criteria within seventy-two hours from the time she arrives at the facility.\footnote{Id.} If she does not, the facility must release the patient unless she provides informed consent to remain as a voluntary patient.\footnote{Slobogin et al., supra note 72, at 705.}

Typically, states have formal adjudicatory procedures for involuntary commitment.\footnote{See, e.g., Fla. Stat. §§ 394.467(6)–(7), 394.459 (2012); Mass. Gen. Laws ch. 123, § 5 (2012); Slobogin et al., supra note 72, at 705.} They require a formal hearing, notice, and counsel, and mandate periodic reviews of the legal status of the committed patient to evaluate whether she continues to meet commitment criteria.\footnote{Slobogin et al., supra note 72, at 705.} Usually, a judge makes the decision to commit, but many states enable the patient to request a jury trial.\footnote{Fasulo v. Arafeh, 378 A.2d 553, 553 (1977); Slobogin et al., supra note 72, at 852.} Typically, states require a review hearing after initial commitment, usually from three months to a year after admission.\footnote{Dayton et al., supra note 59, at § 33:18.}

There is no consensus concerning the appropriate interaction of commitment laws and mental health directive laws.\footnote{See Clausen, supra note 41, at 23 (identifying the ways in which the Uniform Act fails people with mental illness).} One of the reasons the Uniform Law Commission refrained from enacting a model mental health directive statute is this lack of consensus.\footnote{Backlar, supra note 3, at 262; Dunlap, supra note 5, at 347; Elizabeth M. Gallagher, Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals, 4 Psychol. Pub. Pol'y & L. 746, 780 (1998).} The issue of whether a directive refusing treatment limits a doctor’s authority to treat a committed patient is not implicated by generic directives.\footnote{92. Backlar, supra note 3, at 262; Dunlap, supra note 5, at 347; Elizabeth M. Gallagher, Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals, 4 Psychol. Pub. Pol’y & L. 746, 780 (1998).} In the end-of-life context, following a directive refusing intervention does not endanger the safety of others and does not contravene court orders authorizing forced hospitalization and treatment.\footnote{See supra notes 65–94 and accompanying text.} As a result of illness-induced treatment refusal, states have separate mental health directive statutes and only allow a pa-
tient with capacity to revoke a mental health directive. This is in sharp contrast to how generic directive statutes operate, as patients generally may revoke a generic directive at any time, even if they have lost capacity.\footnote{VHA REPORT, supra note 4, at 9 (stating that in thirty-six out of fifty states, incapacitated patients may revoke generic directives; however, in eighteen out of twenty-five states with mental health directive statutes, only patients with capacity may revoke mental health directives).}

b. Mental Health Directives Repeatedly Used

A doctor follows a generic directive during one key time frame in a person’s life: the time before death, after terminal illness or injury has destroyed the patient’s capacity.\footnote{Backlar, supra note 3, at 261–62.} Mental illness, however, is often episodic.\footnote{Nick Anderson, Note, Dr. Jekyll’s Waiver of Mr. Hyde’s Right to Refuse Medical Treatment: Washington’s New Law Authorizing Mental Health-Care Advance Directives Needs Additional Protections, 78 WASH. L. REV. 795, 800 (2003) (stating that some mental illnesses cause patients to fluctuate “between competence and incompetence”); Richard A. Van Dorn et al., Reducing Barriers to Completing Psychiatric Advance Directives, 35 ADMIN. & POL’Y MENTAL HEALTH 440, 441 (2008) (explaining mental health directives allow patients to consent to or refuse treatment in the event an incapacitating psychiatric crisis occurs; these crises illustrate the episodic nature of mental illness); Fisher, supra note 4, at 387 (asserting that “mentally ill patients often experience cyclical periods of competency and incompetency”); Sheetz, supra note 63 at 403 (explaining that some mental illnesses, like bipolar disorder, are episodic).} Doctors may need to follow a mental health directive repeatedly over the patient’s life, whenever the patient suffers from acute episodes.\footnote{Robert D. Miller, Advance Directives for Psychiatric Treatment: A View from the Trenches, 4 PSYCHOL. PUB. POL’Y & L. 728, 734 (1998).} The directive provides guidance for the treatment to be administered in response to each episode.\footnote{Winick, Advance Directive Instruments, supra note 28, at 82.}

It becomes a crisis intervention plan, potentially preventing involuntary treatment, administration of treatment with harmful side effects, or safety risks caused by the use of restraint or seclusion.\footnote{Position Statement 23: Psychiatric Advance Directives, MENTAL HEALTH AMERICA (Sept. 17, 2011), http://www.mentalhealthamerica.net/positions/psychiatric-advance-directives.}

The mental health directive’s potential to be a blueprint for crisis intervention may be one reason most states with specialized mental health directive statutes provide for automatic expiration of mental health directives after two to five years.\footnote{VHA REPORT, supra note 4, at 10; see, e.g., OHIO REV. CODE ANN. § 2135.03 (West 2015); OR. REV. STAT. ANN. § 127.702 (West 2015); TENN. CODE ANN. § 33-6-1003 (2012); TEX. CIV. PRAC. & REM. CODE ANN. § 137.002(b) (West 2015).} Proponents of au-
tomatic expiration argue that it ensures mental health directives continue to reflect the patient’s instructions over time as illnesses and treatment options evolve.\textsuperscript{101} Moreover, automatic expiration incentivizes patients and clinicians to maintain ongoing dialogue to ensure instructions are kept up to date.\textsuperscript{102} No state legislature imposes automatic expiration on generic directives.\textsuperscript{103}

c. Mental Health Treatment Can Be Particularly Intrusive

Mental health treatments can be particularly intrusive and potentially dangerous.\textsuperscript{104} Although antipsychotic medication minimizes psychosis, it can cause serious side effects such as tardive dyskinesia, a disabling neuromotor syndrome.\textsuperscript{105} Because of the potentially harmful side effects, courts and legislatures consider psychiatric medication to be an intrusive treatment.\textsuperscript{106} Electroconvulsive therapy (ECT), a widely used treatment, is considered even more invasive than drug therapy.\textsuperscript{107} Its side effects include memory loss, dental trauma, bone fractures, skin burns, and possible brain damage.\textsuperscript{108} Because of the intrusive nature of ECT, many states do not empower a principal to convey authority, even expressly, to an agent to consent to the patient’s ECT: a court order is required.\textsuperscript{109}

Psychosurgery, defined as any surgery performed to modify or control thoughts, feelings, or behavior rather than treat a known, diagnosed physical disease of the brain, is discredited and dangerous.\textsuperscript{110} Most states prohibit patients from consenting to or conveying authority to an agent to consent to psychosurgery in a

\textsuperscript{101} VHA Report, supra note 4, at 4.
\textsuperscript{102} Id.
\textsuperscript{103} Id.
\textsuperscript{104} Slobogin et al., supra note 72, at 31.
\textsuperscript{105} Id. at 29.
\textsuperscript{109} See Jorgensen, supra note 60, at 36–39 (criticizing restraints on proxy consent to ECT).
directive.\textsuperscript{111} Finally, courts have recognized that institutionalization can traumatize patients and subject them to risks of abuse from fellow patients and from staff.\textsuperscript{112} For this reason, there are strict commitment criteria, and some jurisdictions limit an agent’s authority to hospitalize a principal for inpatient mental health treatment.\textsuperscript{113}

\textbf{B. The Framework for an ADA Challenge}

This Section sets out the framework for an ADA challenge to a statutory scheme that provides greater leeway to a doctor to override a mental health directive than a generic directive. The ADA was enacted in 1990 as a comprehensive effort to remedy discrimination against people with disabilities.\textsuperscript{114} Congress determined that discrimination against people with disabilities persists in such areas as institutionalization, segregation, and relegation to lesser services, programs, and other opportunities.\textsuperscript{115} Title II of the ADA states that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in, or be denied the benefits of, the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.\textsuperscript{116} To prove a Title II violation, the plaintiff must establish that she (1) is a qualified individual with a disability; (2) was excluded from participation in a public entity’s services, programs, or activities or was otherwise discriminated against by a public entity; and (3) that such exclusion or discrimination was due to her disability.\textsuperscript{117} Section 504 of the Rehabilitation Act, which prohibits disability discrimination in federal programs, imposes the same requirements.\textsuperscript{118} Therefore, courts

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\item \textsuperscript{112} O’Connor v. Donaldson, 422 U.S. 563, 574–75 (1975); Paddock v. Chacko, 522 So. 2d 410, 413–14 (Fla. Dist. Ct. App. 1988) (“[M]ental illness may be caused or intensified by institutionalizing mental patients.”).
\item \textsuperscript{113} Clausen, \textit{supra} note 41, at 47–48; see, e.g., \textsc{Tex. Health & Safety Code Ann.} § 166.152(f)(1); \textsc{Wis. Stat. Ann.} § 155.20(2) (West 2013); Cohen v. Bolduc, 760 N.E.2d 714, 718 & n.15 (Mass. 2002) (describing instances where states authorize patients to create directives but do not allow patients to empower agents to consent to inpatient mental health treatment).
\item \textsuperscript{114} Disability Rights New Jersey, Inc. v. Velez, 974 F. Supp. 2d 705, 730 (D.N.J. 2013).
\item \textsuperscript{115} 42 U.S.C §§ 12101(a)(2), (3), (5) (2012).
\item \textsuperscript{116} 42 U.S.C. § 12132 (2012).
\item \textsuperscript{117} Rodriguez v. City of New York, 197 F.3d 611, 618 (2d Cir. 1999).
\item \textsuperscript{118} 29 U.S.C. § 794(a) (2012); \textit{see also} Velez, 974 F. Supp. 2d at 730 (stating that ADA implementing regulations are consistent with regulations implementing Section 504 of the Rehabilitation Act). \textit{See generally Peter Blanck, Disability Civil.}
\end{itemize}
\end{footnotesize}
evaluating a challenge to a mental health directive statute consider Rehabilitation Act and ADA claims in tandem.\textsuperscript{119}

1. Qualified Individual with a Disability

Under the ADA, a “qualified individual with a disability” is a person “with a disability who, with or without reasonable modifications to rules, policies or practices . . . meets the essential eligibility requirements for . . . participation in programs or activities provided by a public entity.”\textsuperscript{120} Generally, individuals challenging a mental health directive statute will be “qualified individuals” under the ADA. Research indicates that only a small percentage of patients execute mental health directives.\textsuperscript{121} Presumably, those who take the time to do so have been diagnosed with a mental illness, which qualifies as a disability under the ADA.\textsuperscript{122} When Congress amended the ADA in 2009, it clarified that the threshold question of whether a person has a disability under the ADA “should not demand extensive analysis.”\textsuperscript{123} Rather, the focus should be on whether the covered entity discriminated against the individual based on her disability.\textsuperscript{124} The recent amendments to the ADA clarify that even episodic illnesses, such as bipolar disorder, may qualify as disabilities under the ADA.\textsuperscript{125} Therefore, any individual with a mental illness who forms a mental health directive, even if her

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RIGHTS LAW AND POLICY 1-9-1-13 (2004) (stating that the enduring hallmark of the Rehabilitation Act is Section 504, which was the first explicit Congressional statement recognizing discrimination against those with disabilities).
\textsuperscript{119} 42 U.S.C. § 12134(b); Velez, 974 F. Supp. 2d at 730.
\textsuperscript{120} 42 U.S.C. § 12131(2) (2012).
\textsuperscript{122} 29 C.F.R. § 1630.2(h)(2) (2012); E.E.O.C. v. J.D. Hunt Transp., Inc., 321 F.3d 69, 74 (2d Cir. 2003).
\textsuperscript{124} \textit{Id.} at 36, 48.
\textsuperscript{125} \textit{Id.} at 35, 41.
mental illness is episodic, is an individual with a disability under the ADA.\textsuperscript{126}

2. Exclusion from Service, Program, or Activity

A person launching an ADA challenge to a mental health directive override provision generally alleges that when doctors have wider latitude to override a mental health patient’s directive than the directives of other patients, the mental health patients are excluded from full participation in the state’s program to protect patient self-determination.\textsuperscript{127} The U.S. Code defines “service, program, or activity” as all of the operations of a department, agency, special purpose district, or other instrumentality of the state or the local government.\textsuperscript{128} When the state makes it easier for a clinician to override a patient’s wishes in a mental health directive than in a generic directive, the state limits the person’s fundamental right to bodily integrity.\textsuperscript{129}

In \textit{Hargrave v. Vermont}, the Second Circuit ruled on an ADA challenge to a Vermont statute setting forth a process that singled out mentally ill prisoners and patients civilly committed for mental illness who had been adjudicated dangerous to themselves or others when they were committed.\textsuperscript{130} The Vermont statute authorized doctors to petition family court to override the advance directives only of civilly committed individuals or prisoners judged mentally ill in order to forcibly medicate them.\textsuperscript{131} For these mentally ill individuals, Vermont did not require appointment of a guardian or revocation of the directive to support doctors’ forced medication in contravention of the directive.\textsuperscript{132} However, for other incapacitated patients, Vermont only allowed doctors to override the directive if the patient revoked the directive or the court ap-

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\item \textsuperscript{126} Id.
\item \textsuperscript{127} See, e.g., \textit{Hargrave v. Vermont}, 340 F.3d 27, 32 (2d Cir. 2003) (alleging that Vermont law permitting abrogation of Durable Power of Attorney executed by patients who have been committed violates Title II of ADA).
\item \textsuperscript{128} 29 U.S.C. § 794(b)(1) (Rehabilitation Act definition of “program or activity” pursuant to nondiscrimination under federal grants and programs); Disability Rights New Jersey, Inc. v. Velez, 974 F. Supp. 2d 705, 736 (D.N.J. 2013).
\item \textsuperscript{129} Cf. \textit{Winick, Advance Directive Instruments, supra} note 28, at 71–72 (suggesting that arguments in favor of enforceability of advance directives are stronger than those against it, and that such directives would likely survive constitutional scrutiny).
\item \textsuperscript{130} 340 F.3d at 31–34.
\item \textsuperscript{131} Id. at 31–32.
\item \textsuperscript{132} Id. at 37.
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pointed a guardian to protect the person’s best interests. The court in Hargrave determined that Vermont excluded these people with mental illness from the relevant state service, program, or activity: the program empowering people to protect their autonomy through advance directives.

In Disability Rights New Jersey, Inc. v. Velez, an organization representing psychiatric patients treated at New Jersey state psychiatric hospitals alleged that patients were forced to consume psychiatric medication against their will and in nonemergency situations, in violation of the ADA. The New Jersey defendants argued that the text of the ADA and the case law interpreting it did not support the plaintiff’s position that the right to refuse treatment is a “service, program, or activity” under the ADA. The court in Velez rejected this defense. The U.S. Code and implementing regulations clarify that ADA coverage extends to all services public entities make available. Courts have interpreted the broad statutory and regulatory language “to apply [ly] to anything a public entity does.” “Program, service, or activity” is a catchall phrase prohibiting all discrimination by a public entity, regardless of context. For example, state health insurance is a “program, service, or activity.” Thus Velez held that New Jersey’s differential treatment, in its handling of a patient’s right to refuse treatment, was a “program, service, or activity” which could not avoid ADA nondiscrimination obligations.

3. Determining Whether Exclusion or Discrimination Was Due to Disability

Individuals alleging that the override provision violates the ADA must prove that the discrimination was due to the individual’s mental illness. A state’s program enabling people to form ad-

133. Id.
134. Id. at 38.
136. Id. at 736.
137. Id.
138. 28 C.F.R. § 35.102(a) (2012).
140. Velez, 974 F. Supp. 2d at 736.
141. Lovell v. Chandler, 303 F.3d 1039, 1053–54 (9th Cir. 2002).
142. Id.
143. Id. at 730; 29 U.S.C § 794(a) (2012).
vance directives discriminates on the basis of mental illness if the program treats a person with mental illness in a particular set of circumstances differently than it treats people who do not have mental illness in the same set of circumstances.\textsuperscript{144}

To prove an ADA violation, it is not necessary to prove the state program discriminated against all people who have the relevant disability, mental illness.\textsuperscript{145} For example, in \textit{Olmstead v. Zimring}, the Court found that the state excluded people from a state program by reason of their mental illness, in violation of the ADA, where the state did not exclude all mentally ill people from the program, but only people who had been institutionalized for mental illness.\textsuperscript{146} \textit{Hargrave} concluded that it was immaterial that the Vermont statute applied only to a subset of people with mental illness.\textsuperscript{147} The Vermont law authorized clinicians to override the directives only of people who were mentally ill, dangerous, committed, or incompetent to make treatment decisions.\textsuperscript{148} Discrimination on the basis of the severity of the disability still violates the ADA.\textsuperscript{149} \textit{Hargrave} noted that of all the patient population incompetent to refuse treatment, only patients committed for mental illness were subject to the directive abrogation procedures.\textsuperscript{150} Vermont established a procedure through which only people with mental illness found to be incompetent would have their directives overridden in family court.\textsuperscript{151} Equally incompetent people who suffered from physical illness or injury would only have their directives overridden in probate court after appointment of a guardian to protect their interests.\textsuperscript{152}

4. Direct Threat Exception

The ADA does not require public entities to allow an individual to participate in or benefit from services or programs where the individual poses a “direct threat” to the health or safety of others.\textsuperscript{153} This is known as the direct threat exception.\textsuperscript{154} The ADA defines “direct threat” as “a significant risk to the health or safety of others that cannot be eliminated by modification of policies . . . or proce-

\textsuperscript{144} Hargrave v. Vermont, 340 F.3d 27, 36–37 (2d Cir. 2003).
\textsuperscript{145} Id. at 36.
\textsuperscript{147} Hargrave, 340 F.3d at 36.
\textsuperscript{148} Id. at 37.
\textsuperscript{149} Id. at 36.
\textsuperscript{150} Id.
\textsuperscript{151} Id. at 37.
\textsuperscript{152} Hargrave, 340 F.3d at 36–37.
\textsuperscript{154} Hargrave, 340 F.3d at 36–37.
dures, or by providing auxiliary aids or services.” The implementing regulations require the public entity to make an individualized assessment of whether the individual poses a direct threat. Assessments must rely on current medical knowledge or best available objective evidence. The public entity must make a reasoned judgment about “the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modification of policies, practices, or procedures . . . will mitigate the risk.”

In *Hargrave*, Vermont argued that the court’s initial dangerousness determination at the time of commitment excluded committed patients from the ADA for the entirety of their commitment under the direct threat exception. *Hargrave* concluded that the direct threat exception was not applicable. Vermont failed to demonstrate that every person subject to the advance directive abrogation procedures posed a direct threat to others sufficient to exclude the person from the ADA. Vermont neglected to make an individualized assessment of the danger the individual posed at the time the individual’s advance directive was overridden.

Under the Vermont procedures in place at the time of the *Hargrave* decision, forty-five days could have passed between the initial commitment order and contravention of the advance directive. After forty-five days of commitment and treatment, many patients will no longer pose a danger to themselves or others. Moreover, commitment in Vermont was based on a court’s determination that the individual posed a danger to self or others. However, the ADA’s direct threat exception requires the person to pose a danger to others.

Similarly, in *Velez*, state defendants argued that patients subject to New Jersey’s procedures for forced psychiatric medication were

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156. 28 C.F.R. § 35.139 (2012) (direct threat exception to nondiscrimination on the basis of disability in state and local governmental services).
157. Id.
158. Id.
159. 340 F.3d at 35.
160. Id. at 36.
161. Id.
162. Id.
163. Id. at 31.
164. Id.; see also infra note 331.
165. *Hargrave*, 340 F.3d at 36.
166. Id.
exempt from ADA protections under the direct threat exception.\textsuperscript{167} The forced medication policy operated as follows. Patients subject to the policy had all been civilly committed due to mental illness based on a court finding that at the time of commitment they were dangerous to themselves or others.\textsuperscript{168} One category of the patients subject to the procedure consisted of patients with conditional extension of commitment pending placement.\textsuperscript{169} These people were initially involuntarily committed but were later determined to no longer be dangerous and were entitled to discharge;\textsuperscript{170} they were not yet discharged, however, because they were awaiting placement.\textsuperscript{171} The policy authorizing forced medication did not apply to voluntarily committed patients.\textsuperscript{172} For these patients, there had never been a judicial finding in a commitment hearing that they were dangerous.\textsuperscript{173} Therefore, they had the right to refuse psychotropic medication outside of an emergency.\textsuperscript{174} The policy provided for administrative, rather than judicial, hearings for the psychiatric patients (both those involuntarily committed and those awaiting placement) to determine their continued dangerousness as a prerequisite to medicate them without their consent.\textsuperscript{175}

\textit{Velez} decided it was unjustified to apply New Jersey’s policy to one category of mental health patients, those patients with conditional extension of commitment pending placement.\textsuperscript{176} A court had determined these patients no longer presented a danger and were eligible for discharge.\textsuperscript{177} These patients were merely awaiting placement.\textsuperscript{178} Defendants argued that the court’s finding of a lack of dangerousness for these patients did not preclude the patients from presenting a danger in the future while in state custody.\textsuperscript{179} This argument was based on the fact that mental illness is often episodic, making dangerousness fluctuate.\textsuperscript{180} \textit{Velez} decided New Jersey’s procedures for forced medication of patients awaiting
placement could not escape ADA protections, as the direct threat exception did not apply.\textsuperscript{181} A court had determined that these patients no longer presented a danger.\textsuperscript{182} Therefore, applying the New Jersey policy to patients awaiting placement was facially discriminatory based on their mental illness.\textsuperscript{183} If any of the patients awaiting placement began to exhibit new signs of dangerousness, the state could follow standard procedures for instituting civil commitment.\textsuperscript{184}

The \textit{Velez} plaintiffs also argued that the direct threat exception did not apply to the patients committed based on parens patriae authority.\textsuperscript{185} A court had committed these patients because they posed a threat to themselves.\textsuperscript{186} No court had ever found that these patients posed a threat to others as required by the direct threat exception.\textsuperscript{187} \textit{Velez} acknowledged an inherent difference between patients committed under parens patriae as opposed to police power authority.\textsuperscript{188} Generally, the principle of self-determination allows the patient to pose a danger to himself.\textsuperscript{189} However, \textit{Velez} stated that its analysis was complicated in the case of people with mental illness committed based on parens patriae authority.\textsuperscript{190} In such instances, the patient has mental illness, is potentially dangerous to himself, and necessarily poses a safety risk.\textsuperscript{191} \textit{Velez} declined to broaden the direct threat exception but claimed it had no need to do so.\textsuperscript{192} The ADA regulations allow the state to impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities.\textsuperscript{193} These requirements must be based on actual risks and not mere speculation or stereotypes about people with disabilities.\textsuperscript{194} \textit{Velez} found adequate justification to support New Jersey’s forced medication policy’s differential treatment of parens patriae committed patients.\textsuperscript{195}

\textsuperscript{181} \textit{Id.}
\textsuperscript{182} \textit{Id.}
\textsuperscript{183} \textit{Id.}
\textsuperscript{184} \textit{Id.} at 738.
\textsuperscript{185} \textit{Velez,} 974 F. Supp. 2d at 738–39.
\textsuperscript{186} \textit{Id.} at 738.
\textsuperscript{187} \textit{Id.}
\textsuperscript{188} \textit{Id.}
\textsuperscript{189} \textit{Id.}
\textsuperscript{190} \textit{Id.}
\textsuperscript{191} \textit{Id.} at 738.
\textsuperscript{192} \textit{Id.} at 738–39.
\textsuperscript{193} \textit{Id.} (discussing 28 C.F.R. § 35.130(h) (2012)).
\textsuperscript{194} \textit{Id.} at 739.
\textsuperscript{195} \textit{Id.}
5. Fundamental Alteration Defense

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

Hargrave rejected the state’s fundamental alteration argument and held that fundamental alteration analysis should focus on the relevant program, which was the advance directive program. Vermont argued that upholding the lower court’s injunction of the directive abrogation procedure would fundamentally alter Vermont’s programs for involuntary treatment of committed patients and civil commitment generally. Hargrave determined that these programs were not the relevant state programs for ADA purposes. Instead, the relevant program was “the statutorily created opportunity to execute [a directive] for health-care and have it recognized and followed.” There was no evidence or even assertion that the injunction would require the state to fundamentally alter the advance directive program. Hargrave based its conclusion on an interpretive regulation, which clarifies that the ADA requires states to make reasonable modifications in policies or practices to avoid discrimination, unless those modifications would constitute a fundamental alteration to the relevant program.

197. 28 C.F.R. § 35.130(b)(7) (2012).
200. Id. at 38.
201. Id.
202. Id.
203. Id. (emphasis omitted) (citation omitted).
204. Id.
205. Hargrave, 340 F.3d at 38.
II.
AN ADA CRITIQUE OF MENTAL HEALTH DIRECTIVE OVERRIDE PROVISIONS

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


The majority of the twenty-five states that have enacted separate mental health directive statutes grant doctors greater authority to override a mental health directive than do their counterpart generic directive statutes.\textsuperscript{206} The typical generic directive statute only authorizes doctors to override a generic directive in limited circumstances.\textsuperscript{207} Generally, the typical generic directive override provision allows for declining to follow patient preferences in a directive that is: (1) outside the standard of care; (2) unavailable; (3) medically ineffective; or (4) illegal.\textsuperscript{208}

One influential example of a generic directive override provision is the override provision in the Uniform Act, which has been adopted by numerous states.\textsuperscript{209} The Uniform Act only allows clinicians to refuse to implement a directive for reasons of conscience or when the directive requires medically ineffective care or treatment contrary to accepted standards.\textsuperscript{210} These are the same circumstances authorizing clinicians to refuse to honor contemporaneous treatment choices expressed by patients with capacity.\textsuperscript{211} Each of these circumstances allows clinicians to refuse to administer requested care and does not allow a clinician to force care on a patient.\textsuperscript{212} The Constitution and tort law provide far greater protection to a patient’s right to refuse treatment than to a pa-

\begin{footnotesize}
\begin{enumerate}
\item See supra note 4 and accompanying text.
\item See supra note 5 and accompanying text.
\item See supra note 5 and accompanying text.
\item Id.
\item Id.
\item Id.
\item Id.
\end{enumerate}
\end{footnotesize}
tient’s right to obtain a particular treatment.\textsuperscript{213} Under the Uniform Act, when the clinician refuses to honor the directive, she must notify the patient, make reasonable efforts to transfer the patient to another facility willing to comply with the directive, and provide continuing care until transfer.\textsuperscript{214}

In Utah, a provider may only decline to follow a generic directive if the provider believes one of the following: (1) the patient or surrogate who made the decision lacks capacity; (2) there is evidence that the surrogate’s instructions contravene the patient’s instructions (or, for a patient who has always lacked capacity, the surrogate’s instructions are inconsistent with the patient’s best interests); (3) there is reasonable doubt regarding the status of the person claiming the right to act as default surrogate; or (4) for reasons of conscience.\textsuperscript{215} If the provider declines to follow the directive, the provider must inform the patient or the surrogate of the reasons for refusing to comply, make a good-faith attempt to resolve the conflict, and provide continuing care until the issue is resolved or until transfer to a facility willing to implement the directive.\textsuperscript{216} These enumerated circumstances all focus on protecting patient autonomy and do not authorize clinicians to force treatment to protect the safety of others.\textsuperscript{217} They essentially allow a doctor to refuse to follow the surrogate’s instructions when there is reason to believe that they do not reflect the patient’s wishes.\textsuperscript{218}

B. Mental Health Directive Override Provisions

Unlike generic directive override provisions, the typical mental health directive override provision allows abrogation of treatment refusals, thereby authorizing forced treatment.\textsuperscript{219} A patient’s rights to bodily integrity and autonomy are squarely implicated when doctors contravene treatment refusals.\textsuperscript{220} Mental health directive override provisions are the antithesis of generic directive override provisions.\textsuperscript{221} Generic directive override provisions often protect patient autonomy.\textsuperscript{222} For example, some allow doctors to refuse to follow surrogate instructions when there is reason to believe surro-

\begin{itemize}
\item \textsuperscript{213} Winick, \textit{Advance Directive Instruments}, supra note 28, at 70.
\item \textsuperscript{214} \textit{Unif. Health-Care Decisions Act} § 7(e)–(f), 9 U.L.A. 27–28 (2012).
\item \textsuperscript{215} \textit{Utah Code Ann.} § 75-2a-115(4)(b) (2012).
\item \textsuperscript{216} Id. § 75-2a-115(4)(c).
\item \textsuperscript{217} Id. § 75-2a-115(4)(b).
\item \textsuperscript{218} Id.
\item \textsuperscript{219} VHA REPORT, supra note 4, at 6–7.
\item \textsuperscript{220} See Winick, \textit{Advance Directive Instruments}, supra note 28, at 73.
\item \textsuperscript{221} VHA REPORT, supra note 4, at 6–7.
\item \textsuperscript{222} See supra Part I.I.A.
\end{itemize}
gate instructions do not reflect a patient’s wishes.223 The typical generic directive override provision does not threaten a patient’s right to bodily integrity because it allows doctors to refuse to administer requested treatment in certain circumstances.224 Moreover, generic directive statutes generally require facilities to make efforts to transfer the patient to another facility willing to honor the directive.225 The typical mental health directive override provision does not require efforts to transfer the patient to a facility willing to honor the directive.226 Mental health directive override provisions are not primarily concerned with protecting patient autonomy.227 Rather, they authorize doctors to violate patient autonomy in certain circumstances.228

Many mental health directive statutes authorize doctors to override a mental health directive in emergencies, pursuant to court order, and in the commitment context.229 In each of these instances, the doctor administers what he deems to be necessary treatment despite a refusal to such treatment in a directive.230 This override formulation violates the antidiscrimination mandate of the ADA.

1. In Emergencies

Generic directive statutes do not typically authorize doctors to override a generic directive in the case of an emergency.231 Such

223. See supra Part II.A.
224. VHA REPORT, supra note 4, at 6–7.
227. VHA REPORT, supra note 4, at 6–7.
228. Id.
229. Id.
230. Id.
231. UNIF. HEALTH-CARE DECISIONS ACT § 7(e)–(f), 9 U.L.A. 27–28 (2012); VHA REPORT, supra note 4, at 6.
override authority would not be necessary or appropriate in an end-of-life scenario. Generic directives allow patients to indicate whether they want to prolong life for as long as possible, accept artificial nutrition and hydration, or donate their organs. People in comas do not present “emergencies endangering safety” the way patients suffering from acute psychotic episodes may.

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

Moreover, these states authorize treatment in contravention of a mental health directive in cases of emergency, even if the patient is not committed. For example, Utah authorizes doctors to administer intrusive mental health treatment contrary to a directive when the patient is committed or in emergencies. In these emergency situations, there is no requirement for a court determination that the patient posed a danger to self or others or was gravely disabled.

A few states impose an additional requirement on clinicians before treating patients in contravention of directives in emergen-

232. Backlar, supra note 3, at 262.
233. UNIF. HEALTH-CARE DECISIONS ACT § 7 (e)-(f).
235. VHA REPORT, supra note 4, at 6.
236. Id.
238. HAW. REV. STAT. § 327G-8.
239. VHA REPORT, supra note 4, at 6.
cies. For example, Louisiana authorizes a clinician to medicate a patient in contravention of her mental health directive when there is an emergency and the patient’s directive has not been effective in reducing the severity of the behavior that caused the emergency.

The mental health directive statutes differ in how they define “emergency.” Louisiana defines emergency to be an instance when the patient presents an imminent and significant danger of physical harm to herself or others. Similarly, Kentucky expressly authorizes a clinician to override treatment refusals in a mental health directive when there is an “emergency endangering a person’s life or posing a serious risk to physical health.”

Idaho, North Carolina, Oregon, Utah, Tennessee, and Illinois define emergency much more broadly. These states authorize clinicians to provide treatment in contravention of a mental health directive in cases of emergency endangering life or health, without clarifying which emergencies endanger health. If “emergency endangering health” is interpreted to include any episode endangering mental health, most acute mental illness episodes potentially justify clinicians in disregarding mental health directives. This is because untreated mental illness episodes often result in deterioration of cognitive functions and, if left untreated, may ultimately lead to psychosis. A broad interpretation of these states’ override provisions potentially authorizes doctors to override mental health directives any time doing so would prevent deterioration of cognitive functions.

Still other states, such as Texas and Washington, do not define what constitutes an emergency. Washington, however, requires a clinician to issue treatment in accordance with a mental

242. See infra notes 243 and 255 and accompanying text.
244. VHA REPORT, supra note 4, at 6–7.
245. Id.
246. KY. STAT. § 202A.426.
248. IDAHO CODE § 66-609.
250. See Anderson, supra note 96, at 801 (relaying legislative testimony that requiring a person to reach a state that meets involuntary commitment criteria can postpone intervention until it is too late).
251. See supra note 23 and accompanying text.
252. Id.
253. TEX. CIV. PRAC. & REM. CODE ANN. § 137.008 (West 2015).
254. WASH. REV. CODE § 71.32.150 (2012).
health directive to the fullest extent possible, unless the clinician finds that there is an emergency and that compliance would endanger any person’s life or health. Arguably, endangering mental health would be sufficient.

States that authorize a doctor to override a mental health directive in emergencies when they do not allow a doctor to do so in the case of a generic directive likely violate the ADA. As indicated above, a person with mental illness is a qualified individual with a disability under the ADA. Blanket authorization for doctors to abrogate the directives of people with mental illness in emergencies when doctors do not have such authority to ignore the advance wishes of other people excludes one group of people—those with mental illness—from a service, program, or activity of the state.\textit{Hargrave} indicates that the relevant program is the state’s statutory program authorizing people to form advance directives and requiring doctors to honor directives.

The key question is whether the direct threat exception exempts states from the ADA in cases of emergencies. The ADA defines direct threats as those presenting significant risks to the health or safety of others that cannot be eliminated by the modification of policies, practices, or procedures, or by the provision of auxiliary aids or services. In determining whether an individual poses a direct threat, the state must make an individualized assessment, based on a physician’s reasonable judgment that relies upon current medical knowledge.

Arguably, the direct threat exception does not exempt many of the statutes allowing abrogation of mental health directives in emergencies from the ADA nondiscrimination mandate. For example, in Idaho, North Carolina, Oregon, Utah, Tennessee, and Illinois, clinicians may abrogate a mental health directive in cases of emergencies endangering the life or health of the patient or others. These states do not clarify whether such emergencies may include those emergencies potentially affecting the patient’s health.

255. Id.
256. Id.
259. Id. at 37.
261. Id.
262. 28 C.F.R. § 35.139 (2012).
263. 42 U.S.C. § 12182(b)(3).
264. See supra notes 247–248 and accompanying text.
mental health. Acute mental health episodes which could result in the deterioration of the patient’s cognitive functions admittedly endanger the patient’s mental health but do not necessarily pose a direct threat to the health or safety of others. First, acute episodes that may lead to deterioration of cognitive functions do not necessarily pose a threat to the physical health and safety of the patient. The ADA direct threat exception refers to situations that endanger physical health. The implementing regulations require an individualized assessment as to the nature, duration, and severity of the risk and the probability that potential injury will actually occur, where potential injury refers to physical injury. Therefore, emergencies that only endanger the mental health of the patient, but not the physical health or safety of the patient or others, do not fall under the direct threat exception of the ADA. Although some emergencies endangering mental health, such as severe depression presenting a risk of suicide, pose a risk of physical injury to the person or other people, mental health emergencies in which the person is neither suicidal nor dangerous to others present no risk of physical injury.

Second, Hargrave concluded that the defendants failed to demonstrate that people committed because they posed a danger to themselves, as opposed to others, fell under the direct threat exception. Hargrave stated that the direct threat defense requires the patient to pose a risk of harm to others. Many state override provisions authorize abrogation of a mental health directive if there is an emergency in which the patient poses a threat to her own health. Such situations do not necessarily pose a risk of harm to others. Pursuant to Hargrave, differential treatment of people with mental illness is not justified under the direct threat exception.

265. See supra notes 247–248 and accompanying text.
266. 42 U.S.C. § 12182(b)(3).
267. See supra Part I.A.3 (setting forth commitment criteria requiring dangerousness which would not allow commitment of patients who only present a risk of injury to their own mental health, not the safety of themselves or others).
268. 28 C.F.R. § 35.139 (2012).
269. Id.
270. Id.
271. See, e.g., Anderson, supra note 96, at 795–96 (describing a mental health emergency in which a person with dissociative identity disorder suffers from an acute episode that is a mental health emergency rendering him unable to work but that does not present a risk of physical injury to anyone).
273. Id.
274. See supra notes 237, 245–46, 248, 255 and accompanying text.
275. See supra note 276 and accompanying text.
unless there is an individualized assessment that the emergency presents a risk of physical harm to others.\textsuperscript{276}

However, there are valid arguments that the direct threat exception exempts a state program that authorizes abrogation of only mental health directives in emergencies.\textsuperscript{277} In Velez, plaintiffs argued that the direct threat exception did not justify the state’s differential treatment of people committed based on parens patriae authority.\textsuperscript{278} Although Velez acknowledged an inherent difference between situations in which patients pose a danger to themselves and situations in which patients pose a danger to others, Velez concluded that the ADA analysis was complicated in the parens patriae commitment scenario.\textsuperscript{279} Velez was reluctant to broaden the direct threat exception but concluded that there would be absurd results if danger to oneself did not fall within its purview.\textsuperscript{280}

More importantly, Velez stated that the ADA regulations anticipated general safety concerns enabling the state to impose requirements necessary for the safe operation of programs, based on actual risks and not speculation or stereotypes.\textsuperscript{281} When a physician, trained in mental illness, overrides a directive because a patient is in the midst of an emergency, the physician necessarily makes an individualized determination based on actual risks, not speculation, stereotypes, or generalizations.\textsuperscript{282} The direct threat exception requires an individualized assessment based on reasonable judgment, relying on current medical knowledge.\textsuperscript{283} The psychiatrist treating the patient is in the best position to make this individualized assessment.\textsuperscript{284}

Moreover, states may argue that preventing doctors from overriding mental health directives in emergencies fundamentally alters state emergency detention and screening programs.\textsuperscript{285} Typically, commitment statutes authorize involuntary emergency admission

\textsuperscript{276} Hargrave, 340 F.3d at 36.

\textsuperscript{277} See infra notes 288–295 and accompanying text.


\textsuperscript{279} Id. at 738.

\textsuperscript{280} Id. at 738–39.

\textsuperscript{281} Id. at 731 (discussing 28 C.F.R. § 35.130(h) (2012)).

\textsuperscript{282} 28 C.F.R. § 35.139 (2012).

\textsuperscript{283} Id.

\textsuperscript{284} Id.; Olmstead v. L.C., ex rel. Zimring, 527 U.S. 581, 610 (1999) (Kennedy, J., concurring) ("[T]he opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.").

and evaluation without a full adjudicatory commitment hearing. The doctor at the receiving facility examines the person to determine if emergency treatment is necessary to protect the safety of the person or others. Therefore, states may argue that provisions authorizing doctors to override mental health directives in emergency situations do not violate the ADA because they fall under the fundamental alteration defense. However, Hargrave rejected this fundamental alteration argument and held that the analysis should focus on the relevant program, the advance directive program, and not the commitment program.

2. Pursuant to Court Order

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

The override provision also fails to specify how recent the court order must be. Would a commitment order authorizing forced treatment be sufficient to override a mental health directive refusing such treatment if the court order was issued six months prior to the date of the proposed forced treatment? Hargrave concluded that the direct threat exception was not applicable when a court’s initial dangerousness determination was made at the time of commitment, but that the state failed to demonstrate that every person subject to directive abrogation procedures posed a direct threat to others at the time of directive abrogation. Hargrave stated that after forty-five days of commitment and treatment, many patients no longer pose a danger to themselves or others. Therefore, mental health directive statutes that authorize directive contraven-

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287. Id. § 394.463(2)(f).
288. Id.
289. Hargrave, 340 F.3d at 38.
291. VHA Report, supra note 4, at 6.
292. See supra note 297 and accompanying text.
293. Hargrave, 340 F.3d at 36.
294. Id.
tion pursuant to court order can be overly broad and may not fall under the direct threat exception. Allowing directive abrogation pursuant to court order, without providing guidance as to the criteria for issuing such orders or the timeframe for the order’s issuance in relation to the dangerousness assessment, fails to ensure that an individualized dangerousness assessment is performed at the time of directive abrogation.

3. In Commitment Context

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

Other states, like Texas, in the absence of an emergency only authorize mental health treatment in contravention of a directive if the patient is under a commitment order and treatment is authorized pursuant to the mental health code. In this instance, merely being committed is insufficient grounds to support treatment in contravention of a mental health directive. The patient must also meet the requirements for authorizing forced treatment articulated in a separate statute. Similarly, in Minnesota, a physician may administer intrusive mental health treatment contrary to a directive of a committed patient only upon order of the committing court. Moreover, in Ohio, a physician may override a person’s mental

295. Id.
300. Id.
health directive when the person is committed and the committing court allows the treatment.\footnote{303. \textit{Ohio Rev. Code Ann.} § 2135.07 (2012).}

Allowing abrogation of patients’ directives if they are committed excludes them from the state’s advance directive program based on their disability.\footnote{304. \textit{Id.}} The advance directive program, not the commitment program, is the relevant program for the purposes of the ADA.\footnote{305. \textit{Hargrave} clarified that it is immaterial that directive abrogation only applies to a subset of people with mental illness, people who are committed. Discrimination based on the severity of the disability still violates the ADA.\footnote{306. \textit{Id.} Moreover, \textit{Hargrave} held that the court’s initial dangerousness determination at the time of commitment is insufficient to ensure that patients continue to fall under the direct threat exception.\footnote{307. \textit{Id.} There must be an individualized dangerousness assessment at the time of directive abrogation.\footnote{308. \textit{Id.}} A period of commitment often renders a person no longer dangerous to herself or others.\footnote{309. \textit{Id.} Under \textit{Hargrave}, the individualized danger-}

\footnote{303. \textit{Id.} (the \textit{Hargrave} court concluded that commitment, which is inpatient mental health treatment, often necessarily renders patients no longer dangerous to themselves or others. This is because mental health treatment is often successful in returning a patient to normal functioning.); \textit{Davoli, supra note 23, at 1045; Mathew M. Large et al., Mental Health Laws that Require Dangerousness for Involuntary Admission May Delay the Initial Treatment of Schizophrenia, 43 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 251, 251 (2008) (“The duration of untreated psychosis . . . [is] the period between the emergence of psychosis and the initiation of adequate treatment with antipsychotic medication.”) The longer the delay between the emergence of symptoms and treatment, the worse the overall prognosis, and the more there is a risk of suicide, serious violence, and homicide. \textit{Id. See also Arizona Department of Health Services, Involuntary Evaluation and Treatment (Civil Commitment) in the State of Arizona 1 (Nov. 2013), http://www.azdhs.gov/bhs/pdf/Involuntary-Evaluation-and-Treatment.pdf. This report states: [M]ental illness is treatable and persons with mental illness can and do recover . . . . Just like treatment for any other medical conditions such as diabetes or high blood pressure, the early detection, intervention and treatment of mental illnesses improves an individual’s prospect for a full recovery and a richer quality of life. Ideally, an individual with mental illness will seek out or voluntarily agree to get treatment . . . . There are times, however, when a person is unable to recognize his/her need for mental health treatment, is unwilling to get help and poses a risk to self or others in the community. If that is the case, involuntary treatment (civil commitment) may become necessary.)}
ousness assessment must conclude, based on objective medical evidence, that the person poses a danger to others.310

However, Velez offers support for the conclusion that patients who pose a risk of harm to themselves also pose a general safety risk.311 According to Velez, ADA regulations allow the state to impose legitimate safety requirements that must be based on actual risks and not mere speculation or stereotypes.312 Even so, without an individualized dangerousness assessment at the time of directive abrogation, allowing blanket authority to force intrusive mental health treatments on all committed patients violates the ADA.313 Even though Velez held that the forced medication procedures of parens patriae committed patients did not violate the ADA, it is important to note that there was an individualized dangerousness assessment in an administrative hearing immediately before the administration of medication in Velez.314 Forced medication was not authorized based on the fact of parens patriae commitment, without a contemporaneous individualized dangerousness assessment.315 Without an individualized dangerousness assessment at the time of directive abrogation, there is no way to ensure that the patient poses an actual risk.316

Moreover, allowing directive abrogation of all committed people could include patients a court has determined no longer pose a danger to themselves or others, but are eligible for release and awaiting placement, as was the case in Velez.317 Velez held that these individuals would not fall under the direct threat exception.318 Broad authority to override the mental health directives of all committed people risks forced medication of hospitalized people awaiting placement who no longer pose a risk of harm.319

310. Hargrave, 340 F.3d at 37.
312. Id. at 739.
313. Id.
314. Id. at 738.
315. Id. at 739.
316. Id.
318. Id.
319. Id.
C. Beyond the ADA: Other Considerations

1. Arguments Supporting More Expansive Override Authority

Mental illness episodes often induce non-therapeutic treatment refusals.\footnote{320}{See Clausen, supra note 41, at 5.} Doctors will have responsibility for caring for “patients who are clinically quite treatable but are allowed to refuse treatment” based on an advance directive.\footnote{321}{Brief of Appellants at 13, Hargrave v. Vermont, 340 F.3d 27 (2d Cir. 2012) (No. 02-7160) [hereinafter Brief of Appellants].} Honoring non-therapeutic refusals of psychiatric treatment prevents many treatable mental illnesses from improving.\footnote{322}{Id. at 5 n.13; Anderson, supra note 96, at 801; Davoli, supra note 23, at 1045; Large, supra note 309, at 251 (asserting that the longer the timeframe between the emergence of psychosis and the initiation of adequate treatment with antipsychotic medication, the worse the overall prognosis, and the increased risk of suicide, serious violence, and homicide).} For some illnesses, such as schizophrenia and bipolar disorder, treatment delays produce worse long-term outcomes.\footnote{323}{Id. at 5 n.13; Anderson, supra note 96, at 801; Davoli, supra note 23, at 1045; Large, supra note 309, at 251 (asserting that the longer the timeframe between the emergence of psychosis and the initiation of adequate treatment with antipsychotic medication, the worse the overall prognosis, and the increased risk of suicide, serious violence, and homicide).} Treatment delays often result in longer hospital stays and lead to deterioration of the patient’s condition.\footnote{324}{Judy Clausen, Bring Ulysses to Florida: Proposed Legislative Relief for Mental Health Patients, 16 MARQ. ELDER’S ADVISOR 1, 28 (2014); DEP’T OF CHILDREN AND FAMILIES, FLA’S BAKER ACT: 2013 FACT SHEET (2013), http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf (stating that the average stay in a state mental health hospital is 1.7 years).} Medication is often the only way to prevent “chronic assaultive and/or self-injurious behaviors.”\footnote{325}{Brief of Appellants, supra note 321, at 27–28; see also Slobogin et al., supra note 72, at 28 (stating that antipsychotic medications are generally effective in alleviating or reducing the symptoms of schizophrenia, a severe mental disorder characterized by psychotic symptoms including hallucinations and paranoia, and antipsychotic medications are regarded as the mainstay of treatment by psychiatrists); see also Large, supra note 309, at 251 (stating that the longer the timeframe between the emergence of the initiation of treatment with antipsychotic medication, the worst overall prognosis, and the increased risk of suicide, serious violence, and homicide); Mark H. Pollock et. al, A Double-Blind Study of the Efficacy of Venlafaxine Extended-Release, Paroxetine, and Placebo in the Treatment of Panic Disorder, 24 DEPRESSION & ANXIETY 1, 10 (2007) (showing medication effective in treating panic disorders); Aysegül Yildiz et al., Efficacy of Antimanic Treatments: Meta-Analysis of Randomized, Controlled Trials, 36 NEUROPSYCHOPHARMACOLOGY 375, 375 (2011) (meta-analysis showing that several medicines had a response rate of 48% for bipolar disorder); Paul Lichtenstein et al., Medication for Attention Deficit-Hyperactivity Disorder and Criminality, 367 New Eng. J. MED. 2006, 2006 (2012) (studies showing population with disorder had a sharply decreased risk of being convicted of crimes while they took medication).} Requiring doctors in state hospitals to follow directives of committed people could alter the state’s program of civil commitment.
The Supreme Court has stated that medical judgments of responsible state officials hold sway in determining the appropriate treatment of committed people.\(^{326}\) The state will be unable to provide necessary treatment to incompetent, committed persons who have refused such treatment in their mental health directives.\(^{327}\) Inflexibly requiring a physician to adhere to a directive does not give deference to the opinion of the responsible treating physician.\(^{328}\)

Providing expansive directive override authority benefits mental health patients.\(^{329}\) In *Olmstead v. L.C.*, the Supreme Court stated that unnecessary institutionalization of people with mental illness is unlawful discrimination under the ADA.\(^{330}\) Not allowing a treating physician to override a patient’s directive refusing medication could produce longer institutionalization, which in itself perpetuates stereotypes and diminishes the quality of life of people with mental disabilities.\(^{331}\) However, not allowing adequate flexibility to override directives that refuse necessary treatment undermines the state’s ability to treat patients in a less restrictive setting.\(^{332}\)

Physicians are in a unique position when they treat patients who have mental health directives. Doctors who disagree with their patients’ generic directives are free to transfer their patients to different facilities.\(^{333}\) However, providers often administer psychiatric treatment in contravention of a directive in the context of civil commitment.\(^{334}\) When physicians treat patients who are involuntarily hospitalized, they do not have the freedom to transfer or discharge the patient if the patient refuses treatment the physician considers essential.\(^{335}\) When these physicians are forced to follow the non-therapeutic wishes of patients voiced in directives, the physicians are in the uncomfortable position of depriving patients of necessary and therapeutic treatment.\(^{336}\)


\(^{327}\) *Brief of Appellants*, *supra* note 321, at 46.

\(^{328}\) *Olmstead*, 527 U.S. at 610.

\(^{329}\) See infra notes 344–346.

\(^{330}\) Olmstead, 527 U.S. at 600.

\(^{331}\) *Brief of Appellants*, *supra* note 321, at 47 (citing *Olmstead*, 527 U.S. at 600–01); Slobogin et al., *supra* note 72, at 28 (stating that the first generation of antipsychotic drugs was a key force in shortening the length of hospitalizations to months or weeks and in allowing many individuals to live outside the hospital setting).

\(^{332}\) *Olmstead*, 527 U.S. at 607.

\(^{333}\) Miller, *supra* note 97, at 734–35.

\(^{334}\) See *supra* notes 59–94 and accompanying text.

\(^{335}\) Miller, *supra* note 97, at 734–35.

\(^{336}\) *Id.*
There are many ways in which state laws treat mental health directives differently than they do generic directives. This is because the issues faced at end of life are distinct from the issues implicated in episodic mental illness. For example, state laws often limit an agent’s ability to consent to certain kinds of intrusive mental health treatments such as involuntary commitment, ECT, and psychosurgery. However, these same states do not place such limits on an agent’s ability to consent to non-mental health treatment. Moreover, the majority of states with separate mental health directive statutes do not allow incapacitated patients to revoke their mental health directives. The counterpart generic directive statutes, in comparison, do not preclude incapacitated patients from revoking generic directives. Also, many mental health directive statutes state that mental health directives expire after a few years, while their counterpart statutes do not provide for automatic expiration of generic directives. Differences between the end-of-life and episodic mental illness contexts justify states regulating mental health directives differently than they do generic directives. The differences between generic and mental health directive statutes support more expansive override authority in the mental health context.

Reasonable authority to override non-therapeutic treatment refusals is pivotal in the effort to encourage the widespread use of mental health directives, which will result in the best patient care. Creating a directive gives the patient a sense of empowerment and encourages self-responsibility. The planning process is therapeutic because it provides patients opportunities to analyze the patterns of their illnesses and prevent crisis situations. Patients perceive treatment to be more self-determined because direc-

337. See supra notes 55–113 and accompanying text.
338. See supra note 3 and accompanying text.
339. See supra notes 104–113 and accompanying text.
340. See supra notes 104–113 accompanying text.
341. See supra note 94 and accompanying text.
342. Id.
343. Brief of Appellants, supra note 921, at 57–58 (citing Robert D. Fleischner, Advance Directives for Mental Health Care: An Analysis of State Statutes, 4 PSYCH. PUB. POL’y & L. 788, 796 (1998)).
344. See id. at 58 n.15 (“This [difference between statutes] may reflect the likelihood of significant changes in available mental health treatments over time.”).
345. Id.
346. See infra notes 362–368 and accompanying text.
347. Sheetz, supra note 63, at 406–07.
tives allow them to co-author individualized crisis prevention plans. Without clear, reasonable override authority, doctors will be legitimately concerned that non-therapeutic refusals in directives will obstruct their ability to care for patients, respond to emergencies, and prevent danger. Studies indicate a lack of support for mental health directives by clinicians. This is because doctors fear that directives will prevent them from rendering necessary intervention or court-ordered or emergency care. Reasonable override authority assuages these concerns and encourages the use of directives.

2. Arguments Against More Expansive Override Authority

When a state gives greater leeway to doctors to override mental health directives than generic directives, the state deters people with mental illness from forming mental health directives. Why form a directive if it will not be honored? In fact, permitting people with mental illness to effectuate their treatment preferences may be more important to positive health outcomes than short-term clinical improvement. Allowing a doctor to override a


351. Swanson, Overriding, supra note 13, at 83.

352. Id.

353. See infra Part III.A.

354. See generally U.S. DEP’T OF HEALTH AND HUMAN SERV., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 1, 1 (1999) (asserting that when medication is administered to a refusing patient, the risks of the medication are increased and the likelihood of positive treatment outcomes is diminished); Paul S. Applebaum & Thomas Guteh, Drug Refusal: A Study of Psychiatric Inpatients, 137 Am. J. of Psychiatry, 340, 345 (1980) (noting that allowing patients to decline medication as a matter of clinical policy does not seriously impair overall treatment and yields some positive advantages); Phil Brown, Psychiatric Treatment Refusal, Patient Competence and Informed Consent, Int’l J. of Psychiatry, 83, 85–89 (1986) (asserting that the impact of recognizing the right to refuse treatment on institutional functioning was minimal); Bruce J. Winick, The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis, 17 Int’l J. & Psychiatry, 99, 101–02 (1994) (asserting that patient acceptance of treatment is an important indicator of treatment success); Pamela J. Fischer & William R. Breakey, Homelessness and Mental Health: An Overview, 14 Int’l J. Mental Health 6, 29 (1986) (stating that many homeless people with mental illness opt out of the mental health system and choose life in the streets to avoid the unwanted side effects of psychotropic medications); Elbogen et al., supra note 349, at 275, 285 (2007) (reporting on a study revealing that subjects reported high satisfaction with facilitated, one-on-one directive intervention and theorizing that patients with directives perceive treatment to be more self-determined because directives allow patients to co-author individualized crisis
mental health directive prevents a competent person with a mental disability from having her treatment preferences honored.\textsuperscript{355} People who form mental health directives often have episodic illnesses and have previous experience with treatment, side effects, and outcomes.\textsuperscript{356} The patients are often in the best position to determine the care they need and to refuse care that is ineffective or harmful.\textsuperscript{357}

Mental health treatments are particularly intrusive.\textsuperscript{358} Therefore, obtaining valid informed consent is paramount.\textsuperscript{359} When a doctor overrides a mental health directive, there is no informed consent.\textsuperscript{360} Overriding a treatment refusal is a serious invasion of personal privacy and bodily integrity.\textsuperscript{361}

Providing greater override authority to doctors to nullify the wishes of patients with mental illness undermines parity for mental health treatment.\textsuperscript{362} When states decide to give mental health directives less authority than other forms of advance directives, they per-prevention plans); Sheetz, supra note 63, at 406–07 (stating that the process of creating a directive gives the patient a sense of empowerment and encourages self-responsibility); Winick, Advance Directive Instruments, supra note 28, at 81–82 (the directive creation process is therapeutic because it allows patients to analyze the patterns of their illnesses).

\textsuperscript{355.} See, e.g., Swanson, Overriding, supra note 13, at 78; Dunlap, supra note 5, at 364–371.

\textsuperscript{356.} See Jeffrey W. Swanson et al., Psychiatric Advance Directives: An Alternative to Coercive Treatment, 63 Psychiatry 160, 161 (2000) [hereinafter Swanson, Coercive Treatment].

\textsuperscript{357.} Swanson, Coercive Treatment, supra note 356, at 161–62 (asserting that “the episodic nature of psychiatric illness may provide the patient with ample experience regarding what to expect and how best to manage the onset of symptoms that can impair decision-making capacity,” and that creating directives encourages patients to reflect upon their illnesses and past treatments, identify early symptoms signaling relapse, recall treatments that have worked, and choose a person they trust to carry out their wishes for crisis intervention).

\textsuperscript{358.} See supra Part I.A.3; In re Rosa M., 597 N.Y.S.2d 544, 544 (1991) (requiring hospital to honor rejection of ECT in a directive even after patient lost capacity).


\textsuperscript{362.} VHA REPORT, supra note 4, at 6.
petuate negative stereotypes about people with mental illness.\textsuperscript{363} Ending such stereotypes is one of the goals of the ADA.\textsuperscript{364} Providing more expansive override authority in the mental health context illustrates mental health exceptionalism, which is the imposition of burdens on people with mental illness when such burdens are not imposed on other patients.\textsuperscript{365} The typical generic directive override provision is tailored to protect patient autonomy, but the typical mental health directive override provision seems crafted primarily to allow authority to intrude on patient autonomy.\textsuperscript{366} This sends the message that the treatment preferences of people with mental illness deserve less respect than the preferences of everyone else.\textsuperscript{367} Over the last several decades, laws that exclude civilly committed people or mental health patients from exercising their civil rights or participating in legislatively created benefit programs have been found unlawful.\textsuperscript{368} For example, in\ Manhattan State Citizens’ Group v. Bass, a federal district court held that a law that precluded involuntarily committed people from voting violated the Equal Protection Clause.\textsuperscript{369} Moreover, a statutory override provision authorizing doctors to abrogate a mental health directive and force treatment on a patient potentially violates the Due Process Clause.\textsuperscript{370} In\ Velez, the plaintiff alleged that the forced medication procedures violated the patient’s due process rights.\textsuperscript{371} Undoubtedly, individuals have a protected liberty interest in avoiding unwanted mental health treat-

\textsuperscript{363} Id.
\textsuperscript{365} VHA \textit{Report}, \textit{supra} note 4, at 6.
\textsuperscript{366} See \textit{supra} Part II.B.
\textsuperscript{367} VHA \textit{Report}, \textit{supra} note 4, at 6–7.
\textsuperscript{368} \textit{E.g.}, Manhattan State Citizens’ Grp., Inc. v. Bass, 524 F. Supp. 1279, 1274–75 (S.D.N.Y. 1981) (finding that a law precluding individuals who were involuntarily committed from voting was unconstitutional); Allen v. Heckler, 780 F.2d 64, 66, 68–69 (D.C. Cir. 1985) (finding that Section 5014 of the Rehabilitation Act protected, in some respects, certain formerly hospitalized patients who were relegated to noncompetitive civil service status); Doe v. Rowe, 156 F. Supp. 2d 35, 52 (D. Me. 2001) (striking down statutory provision restricting a subset of people with mental disabilities from voting); Doe v. Stincer, 990 F. Supp. 1427 (S.D.Fla. 1997) (finding that a statute requiring facilities to give former patients unfettered access to treatment records but permitting the facilities to deny access to mental health treatment records violated the ADA); Brief of National Association of Protection and Advocacy Systems et al. as Amici Curiae Supporting Appellees at 9, Hargrave v. Vermont, 340 F.3d 27 (2d Cir. 2003), (No. 02-7160).
\textsuperscript{369} 524 F. Supp. at 1275.
\textsuperscript{371} Id. at 723–29.
Due process analysis is outside the scope of this Article; however, abrogation of mental health directives involves forced treatment and thus implicates the Due Process Clause. Due process challenges to forced medication procedures are plentiful.

III.
STRIKING THE RIGHT BALANCE:
GUIDANCE FOR LAWMAKERS

The purpose of this Part is to provide a model advance directive override provision for states to adopt. Part III.A articulates two recommended override provisions, one from the National Ethics Committee of the Veterans Health Administration and the other from Professor Bruce Winick. The VHA Committee’s approach fails to allow flexibility to clinicians to respond to emergencies endangering human safety. Professor Winick’s approach focuses on the wrong issue, the basis for commitment, and fails to require an individualized dangerousness assessment at the time of directive abrogation. Part III.B sets forth this Article’s model override provision, which allows flexibility to respond to emergencies endangering human safety and complies with the ADA. It also resolves how commitment law and mental health advance directive law should interact.

A. Analysis of Other Proposals

1. VHA Committee Recommendation

In a 2008 report, the VHA Committee conducted an ethical analysis of state advance directive laws. The VHA Committee observed that states generally provide far more expansive override authority in mental health directive statutes than in generic directive statutes. The report concluded that override provisions that respect mental health directives less than generic directives undermine parity for mental health treatment and illustrate mental health exceptionalism. However, the VHA Committee commended current VHA policy requiring doctors to follow mental health directives just as they must follow generic directives, provid-
The VHA Committee recommended that clinicians respect patient preferences expressed in mental health directives just as they would preferences in generic directives. The report asserted that the typical state statutory grants of override authority in the mental health context, (1) commitment, (2) emergencies, or (3) determinations that the treatment is essential, do not, in and of themselves, justify overriding a directive. The VHA Committee refused to identify special circumstances justifying clinicians in overriding mental health directives.

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

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


390. Winick, Advance Directive Instruments, supra note 28, at 72–73; Swanson, Overriding, supra note 13, at 79.

391. VHA REPORT, supra note 4, at 6–7.

392. Id.

393. Id.

394. Id.

395. Id.

396. Id.


plies with the ADA and allows clinicians to respond to emergencies endangering the health and safety of others.\footnote{399. See supra Part III.A.}

2. Professor Bruce Winick’s Recommendation

In 1996, Professor Bruce Winick authored an article exploring the potential for mental health directives to change society’s perception of involuntary commitment and forced treatment issues.\footnote{400. Winick, Advance Directive Instruments, supra note 28, at 60–61.} In 1996, statutes regulating mental health directives did not exist as they do today.\footnote{401. VHA REPORT, supra note 4, at 14-15.} In his article, Professor Winick identifies instances in which he believes that the state should authorize clinicians to override a mental health directive.\footnote{402. Winick, Advance Directive Instruments, supra note 28, at 70–72.} Professor Winick recognizes that the Constitution and tort law provide far greater protection to a patient’s right to refuse treatment than they do to a patient’s right to obtain a particular treatment.\footnote{403. \textit{Id}.} Therefore, clinicians should have greater latitude to override a mental health directive consenting to treatment than one refusing treatment.\footnote{404. \textit{Id}. at 71.} Clinicians should not be required to administer treatment to which a patient consented in a directive when the treatment is unlawful, unapproved by the FDA, in excess of the patient’s financial resources, or prohibited by the clinician’s professional ethics.\footnote{405. \textit{Id}.} Doctors should have override authority (whether for a mental health or generic directive) when the directive consents to clinically inappropriate or unethical treatment, or treatment that would violate informed consent principles.\footnote{406. \textit{Id}. at 72.}

When the state allows doctors to force treatment or hospitalization on a patient whose directive refuses such treatment, the patient’s due process and statutory rights to refuse medical treatment are implicated.\footnote{407. \textit{See id.} at 73.} Professor Winick asserts that when the state interest in overriding a mental health directive is based on parens patriae commitment authority, the patient’s right to bodily integrity and autonomy should prevail.\footnote{408. Winick, Advance Directive Instruments, supra note 28, at 73.} Doctors should not be able to override a mental health directive based merely on the fact the patient was committed based on parens patriae grounds.\footnote{409. \textit{Id}. at 73–74.}
Professor Winick asserts that a mental health directive should not control in situations in which the state interest in hospitalization or forced treatment is based on the state’s police power.\textsuperscript{410} He defines police power commitment as commitment to prevent the patient’s suicide or harm to others.\textsuperscript{411} The patient’s autonomy interest supporting the enforcement of the mental health directive refusing hospitalization and treatment does not outweigh the state’s interest in preventing suicide or protecting other people’s safety.\textsuperscript{412} Professor Winick recommends that commitment and forced treatment laws based on the police power should prevail over preferences in mental health directives.\textsuperscript{413} However, when commitment is based only on parens patriae authority, treatment and commitment should only occur in the absence of a mental health directive refusing hospitalization or treatment.\textsuperscript{414}

Professor Winick’s article was published before the \textit{Hargrave} and \textit{Velez} decisions.\textsuperscript{415} His approach aimed to address due process concerns, not ADA concerns.\textsuperscript{416} In light of \textit{Hargrave} and \textit{Velez}, however, without an individualized dangerousness assessment at the time of directive abrogation, Professor Winick’s approach potentially violates the ADA. Under the ADA, a person with mental illness committed on police power grounds is a “qualified individual with a disability.”\textsuperscript{417} Professor Winick recommends an override provision allowing clinicians to abrogate mental health directives of patients committed based on a state’s police power.\textsuperscript{418} Such an override provision excludes these committed individuals from the state program allowing patients to determine health-care to be administered when they lack capacity.\textsuperscript{419} When individuals who have been committed under a state’s police power are subject to directive abrogation, when other people are not, their exclusion from the state advance directive program is due to the disability of mental illness.\textsuperscript{420}

\begin{thebibliography}{1}
\bibitem{410} Id. at 73.
\bibitem{411} Id.
\bibitem{412} Id. at 73–74.
\bibitem{413} Id. at 74.
\bibitem{414} Winick, \textit{Advance Directive Instruments}, supra note 28, at 70–73.
\bibitem{416} Winick, \textit{Advance Directive Instruments}, supra note 28, at 70–73.
\bibitem{417} \textit{See supra} Part I.B.
\bibitem{418} Winick, \textit{Advance Directive Instruments}, supra note 28, at 70–73.
\bibitem{419} \textit{Hargrave}, 340 F.3d at 37–38.
\bibitem{420} Id. at 36.
\end{thebibliography}
Professor Winick defines police power commitment to include commitment to prevent the patient’s suicide. There is no consensus that parens patriae commitment authorizes commitment to prevent suicide. Presumably, under Professor Winick’s definition, parens patriae commitment does not include commitment to prevent suicide but includes commitment in situations when mental illness has caused the person to be unable to provide for her own basic needs. Under Hargrave, it is doubtful that Professor Winick’s approach, allowing for directive abrogation to prevent suicide, would fall under the ADA’s direct threat exception. Hargrave concluded that commitment based on a court determination that the individual posed a danger to herself would not necessarily fall under the direct threat exception, which requires the person to pose a danger to others.

However, assuming an individualized dangerousness assessment is performed at the time of directive abrogation, Velez holds that the ADA authorizes directive contravention if the person presents a suicide risk. Velez defines parens patriae commitment as commitment of people with mental illness who are potentially dangerous to themselves. Therefore, under Velez, parens patriae commitment includes commitment based on a risk of suicide. In contrast, Professor Winick justifies commitment to prevent suicide on police power grounds. Velez acknowledges that the direct threat exception technically requires that the individual pose a risk to others, not just herself. However, Velez recognized that the analysis is complicated in the case of mental illness resulting in commitment based on parens patriae authority because people who pose a danger to themselves often pose a safety risk to others. Moreover, Velez stated that there would be absurd results if situations endangering the patient’s life did not fall within the purview of the ADA direct threat exception. Finally, Velez pointed

421. Id.
422. See supra Part I.A.3.
424. Hargrave, 340 F.3d 36.
425. Id.
427. Id.
428. Id.
431. Id.
432. Id.
out that ADA regulations encompass general safety concerns, which empower the state to impose requirements necessary for the safe operation of programs based on actual risks.\textsuperscript{433} When a doctor overrides a directive to prevent suicide, she makes an individualized determination based on her expert assessment on present, actual risks.\textsuperscript{434}

Therefore, Professor Winick’s approach focuses on the wrong issue: the basis for the original commitment.\textsuperscript{435} His approach allows for mental health directive abrogation based on police power commitment, not parens patriae commitment.\textsuperscript{436} Velez clarifies that people with mental illness who pose a danger to themselves also often present a safety risk to others.\textsuperscript{437} The key to crafting an ADA compliant override provision that also allows flexibility to protect human safety is to require an individualized dangerousness assessment at the time of directive abrogation.\textsuperscript{438} Allowing a physician to override a directive based solely on a court determination of dangerousness to self or others at the time of the original commitment violates the ADA.\textsuperscript{439} Admittedly, at the time of the original commitment, the person was adjudicated dangerous to herself or others.\textsuperscript{440} However, after a period of hospitalization, the committed patient may no longer pose any such danger.\textsuperscript{441} Without an individualized dangerousness assessment at the time of directive abrogation, people may be subject to forced treatment when they are not dangerous.\textsuperscript{442}

\textbf{B. Legislative Proposal: A Model Override Provision}

The advance directive override provision proposed below balances patients’ rights of autonomy with the state’s interest in preventing risks to human health and safety. This Article’s ap-
approach responds to Hargrave’s invitation to craft an advance directive override provision that is ADA compliant.\footnote{Hargrave, 340 F.3d at 38.} Moreover, the model override provision complies with commitment law by only allowing directive abrogation when the patient is dangerous to herself or others.\footnote{See supra Part I.A.3.} States should use this override provision for all advance directives:

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

1) Inconsistent with Standards: In the opinion of the health-care professional, compliance with the instruction is inconsistent with generally accepted health-care standards applicable to the health-care provider or institution;

2) Medically Ineffective: In the opinion of the health-care professional, the requested treatment is medically ineffective;

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

4) Violates Conscience: Compliance with the instruction would violate the health-care professional’s conscience;\footnote{See Unif. Health-Care Decisions Act § 7(e)-(f), 9 U.L.A. 27–28 (2012).} or

5) Poses Direct Threat: In the opinion of the health-care professional, following the instruction poses a direct threat to the health or safety of others or, in the mental health emergency context, poses a direct threat to the patient’s life. The health-care professional must make a written finding in the patient’s medical records explaining her determination that following the instruction poses a direct threat to the health or safety of others or, in the mental health emergency context, to the patient’s life. Authority to refuse to follow an instruction based on a health-care professional’s determination of a direct threat expires after seventy-two hours.

6) Directive Contravention Court Ordered: After seventy-two hours, contravention of the instruction must be authorized by court order as follows. A court may grant an order authorizing contravention of the instruction based on its determination that following the instruction poses a direct threat, in the mental health emergency context, to the patient’s life, and in
all contexts, to the health or safety of others. Such direct threat means there is a significant risk to the patient’s life, in the mental health emergency context, and in all contexts, to the health or safety of others that cannot be eliminated by reasonable modification of policies, practices, or procedures or by the provision of auxiliary aids or services. In determining whether an individual poses a direct threat, there must be an individualized assessment, based on the medical professional’s reasonable judgment, relying on current medical knowledge or on the best available objective evidence to ascertain the nature, duration, and severity of the risk, the probability potential injury will actually occur, and whether reasonable modifications in policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk. Contravention of an instruction under this subsection must also comply with any additional requirements imposed by law.\textsuperscript{446}

7) Responsibilities if Directive Contravention: If a health-care professional declines to follow an instruction for the reasons above, the institution shall promptly inform the patient, if possible, and any designated agent. If the professional declines to follow the directive for the reasons stated in 1–4, but not 5–6, the institution shall:

a) Provide continuing care to the patient until a transfer can be effected; and

b) Unless the patient or designated agent refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution willing to comply with the instruction.

This override provision allows clinicians flexibility to respond to mental health emergencies that present a substantial risk to the patient’s life and all emergencies that threaten the health or safety of others. The model provision meets the Hargrave challenge to craft an ADA compliant override provision.\textsuperscript{447} It only treats mental health crisis situations differently in one narrow situation: emergencies that threaten the patient’s life. Differential treatment in this narrow context is warranted because terminally ill people have constitutional, common law, and statutory rights to refuse life-preserving medication, nutrition and hydration.\textsuperscript{448} Although patients with mental illness also have such rights to bodily integrity and self-determination, commitment laws allow doctors to override these rights and administer treatment in the case of certain mental health

\textsuperscript{446} See, e.g., supra Part I.A.3.a (specifying typical requirements for involuntary hospitalization and treatment for mental illness).


\textsuperscript{448} See supra note 23 and accompanying text.
emergencies. The proposed override provision also meets the VHA Committee challenge; it does not undermine parity for mental health treatment and refuses to engage in unjustified mental health exceptionalism. The override provision works the same way for all people with the narrow exception of allowing directive abrogation when a mental illness episode causes a direct threat to the patient’s life. It strikes the right balance between protecting against threats to human safety and safeguarding all patients’ rights to individual autonomy.

The model approach protects the health or safety of others more effectively than the VHA Committee approach because it allows health-care professionals to respond to emergency situations to prevent imminent risks to human safety. The VHA Committee’s recommendation fails to adequately protect human safety because it recommends the standard generic directive override provisions for all situations. The VHA Committee describes the typical generic directive override provision as only allowing contravention of directives that request treatment that is medically unacceptable, ineffective, unavailable, or unethical; this does not expressly authorize providers to respond to emergencies which endanger the health or safety of others or patient suicide caused by acute mental health emergencies. The model approach adopts the Uniform Act’s override provision because it is probably the most influential generic directive override provision and was adopted by the Uniform Law Commission after thorough study and investigation. The model approach also adds override authority to respond to emergencies endangering the health or safety of others or when acute mental illness episodes have created a direct threat of suicide.

Moreover, the model approach provides needed guidance on the interaction between mental health directive law and commitment law. The model approach complies with the typical state involuntary commitment law because it authorizes doctors to administer emergency treatment to a patient based on the doctor’s determination that the patient is dangerous to herself or others.

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449. See supra Part I.A.3.
450. VHA REPORT, supra note 4, at 6–7.
451. Id.
452. Id.
453. Id.
455. DAYTON ET AL., supra note 59, at § 33:18.
456. See supra Part I.A.
However, this authority usually expires after seventy-two hours.\textsuperscript{457} Continued hospitalization and treatment must be authorized by a court. The seventy-two hour time frame is necessary to comply with commitment law because it empowers doctors to respond to dangerous emergencies by authorizing emergency intervention without a court order, based only on the doctor’s determination for a short period of time.\textsuperscript{458} This seventy-two hour timeframe provides sufficient time for the facility to obtain court authority to continue treatment.\textsuperscript{459} After the seventy-two hour timeframe, continued treatment without consent must be authorized by a court.\textsuperscript{460} The model approach provides courts guidance as to when they may issue such orders authorizing directive abrogation.\textsuperscript{461} Some jurisdictions may impose commitment criteria that are more stringent than the dangerousness assessment imposed by the ADA direct threat exception.\textsuperscript{462} For example, the jurisdiction may impose an overt act requirement evidencing the patient’s dangerousness.\textsuperscript{463} The model override provision addresses these situations in which the commitment criteria may be more stringent than the direct threat exception criteria. It clarifies that directive contravention must also comply with any additional applicable legal requirements.

The model approach protects patient autonomy more than many statutes that authorize mental health directive abrogation when patients are committed (without requiring an individualized risk assessment at the time of directive abrogation), when there is an emergency (without further defining emergency and potentially covering situations which do not fall under the direct threat exception), and when there is a court order (without providing guidance as to when courts may issue such orders).\textsuperscript{464} This Article’s model focuses on a key issue under the ADA: the individualized dangerousness assessment at the time of directive abrogation.\textsuperscript{465} The model provision mirrors ADA regulations defining the scope of the direct threat exception.\textsuperscript{466} Following \textit{Velez}, the model approach recognizes that the line between endangering the self and endangering others is blurry because of the unpredictable

\textsuperscript{457} See, e.g., FLA. STAT. § 394.463 (2012).
\textsuperscript{458} Id.
\textsuperscript{459} Id.
\textsuperscript{460} Id.
\textsuperscript{461} See supra Part III.B.
\textsuperscript{462} See, e.g., KAN. STAT. ANN. § 59-2946(f) (2012).
\textsuperscript{463} Id.
\textsuperscript{464} See supra Part II.B.
\textsuperscript{465} Hargrave v. Vermont, 340 F.3d 27, 36 (2003).
\textsuperscript{466} 28 C.F.R. § 35.139 (2012).
nature of mental illness.\textsuperscript{467} When a mental health emergency renders the patient a danger to him or herself, the health and safety of others can also be endangered.\textsuperscript{468} This is not the case in the end-of-life context.\textsuperscript{469} Following the instructions of a terminally ill patient whose directive refuses artificial nutrition and hydration endangers only the health and safety of that patient.\textsuperscript{470} However, following the generic directive does not, in the end-of-life scenario, endanger the health or safety of others.\textsuperscript{471} Mental health emergencies threatening the patient’s life fall under the technical language of the direct threat exception because such emergencies also threaten the health and safety of others.\textsuperscript{472} Moreover, ADA regulations encompass general safety concerns enabling the state to impose requirements necessary for the safe operation of programs, based on actual risks.\textsuperscript{473} When a physician abrogates a mental health directive to prevent suicide, the physician makes an individualized dangerousness determination based on actual, immediate risks.\textsuperscript{474}

The recommended approach protects against abuse and safeguards patient autonomy more effectively than Professor Winick’s approach, which recommends authorizing mental health directive abrogation for police power commitment but not for parens patriae commitment.\textsuperscript{475} Professor Winick fails to expressly require an individualized assessment of risk to the health or safety of others or the patient at the time of directive abrogation.\textsuperscript{476} The fact that a patient is committed under police power authority does not necessarily mean the patient presents a risk of harm to the patient or others at the time of directive abrogation.\textsuperscript{477} Professor Winick’s approach, as well as the approach of several state mental health directive statutes, fails to recognize that many committed patients, after a period of commitment and treatment, may no longer present a direct threat to the health or safety of themselves or others.\textsuperscript{478}

\begin{thebibliography}{99}
\bibitem{468} Id.
\bibitem{469} See supra note 23 and accompanying text.
\bibitem{470} Id.
\bibitem{471} See supra note 23 and accompanying text.
\bibitem{472} Velez, 974 F. Supp. 2d at 738–39.
\bibitem{473} Id.
\bibitem{474} Id.
\bibitem{475} Winick, \textit{Advance Directive Instruments}, supra note 28, at 73.
\bibitem{476} Id.
\bibitem{477} Id.
\bibitem{478} Id.
\end{thebibliography}
CONCLUSION

This Article’s model approach complies with the ADA and strikes the right balance between protecting human safety and safeguarding patient autonomy. For all forms of directives, it adopts the Uniform Act’s override provision and allows directive contravention when following the directive poses a direct threat to the health or safety of others.479 Such emergencies may involve mental illness but may also involve unrelated issues.480 Directive abrogation in such instances falls under the direct threat exception and does not violate the ADA.481

This Article’s model also allows directive contravention when there is a direct threat to the patient’s life caused by a mental health emergency. It is necessary to treat people with mental illness differently in this narrow circumstance because terminally ill people have constitutional and statutory rights to refuse life-sustaining treatment.482 Not only does the recommended approach comply with the ADA, it clarifies the relationship between mental health directive laws and commitment laws.483 States that adopt the model approach will provide clinicians much-needed guidance in responding to situations in which a patient’s directive refuses treatment necessary to prevent a risk of harm to the health and safety of others or suicide caused by a mental health emergency.

479. See supra Part III.B.
480. Id.
482. See supra note 23 and accompanying text.
483. See supra Part III.B.