

VOLUNTARY ADMISSION AND TREATMENT OF INCOMPETENT PERSONS WITH A MENTAL ILLNESS

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I. INTRODUCTION

Many people with a mental illness are able to care for themselves and seek mental health treatment on their own. In some cases, however, they may experience temporary periods of mental illness or may have progressed to a point in their disease when they are incompetent to make medical treatment decisions for themselves. These individuals may be experiencing a period of severe depression or suffering from Alzheimer’s disease and do not meet the requirements for judicial commitment. Therefore, a third party should be available to consent to voluntary admission to a mental health facility and mental health treatment on behalf of the incompetent person.

The primary goal of this article is to demonstrate the need for allowing a broad range of persons to legally consent for an incompetent person to voluntary admission and treatment of a mental illness. Many states have adopted surrogate decision-maker statutes that permit family and friends to substitute their consent in the absence of a legal guardian or health care power of attorney appointed by the patient.¹ The author recommends adoption of such a statute in Minnesota and other states that do not permit a third party to consent to mental health treatment and admissions.

With certain protections for abuse, surrogate decision-maker statutes will benefit many patients with a mental illness. If state law does not permit anyone, or even a narrow range of persons to consent, an incompetent person may have difficulty being admitted or treated voluntarily. Furthermore, the incompetent person may not meet state requirements for civil commitment and would go untreated. Even if eligible for commitment, judicial intervention is time-consuming and potentially humiliating and dehumanizing for patients and their families.

1. See, e.g., CONN. GEN. STAT. § 19a-571 (1989); GA. CODE ANN. § 31-9-2 (2001); ME. REV. STAT. ANN. tit. 18-A, § 5-805 (West Supp. 2002).

II. INFORMED CONSENT

In the United States, there is a belief in individual autonomy, which includes an individual's "right to be free from nonconsensual interference with his or her person, and a basic moral principle that it is wrong to force another to act against his or her will."² This principle was articulated in the medical context by Justice Cardozo who said, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body"³

It is well-established that health care providers must discuss with their patients the risks, benefits, and alternatives of a procedure they are about to undergo. In some instances, though, a patient is unable to give consent because he or she is unconscious or lacks the mental capacity. Generally, in the absence of an advanced directive or legal guardian, health care providers can obtain consent from next-of-kin when a patient is unable to consent on his or her own.

This practice is generally prohibited, or at least not expressly permitted in many states including Minnesota, for patients seeking voluntary admission to a mental health facility or mental health treatment. There are several reasons for the distinction. Health care providers are often reluctant to make a determination that a patient is incompetent. There are no blood tests or other diagnostic tools such as those used to diagnose physical conditions. Providers must rely on subjective criteria based on a patient's behavior. Also, the concept of voluntary admission of a patient with a mental illness is relatively new. At one time, patients with a mental illness were always committed. Finally, there is a concern that family members who are allowed to consent on behalf of a mentally ill person will admit them and "throw away the key."

III. PREFERENCE OF VOLUNTARY ADMISSION OVER CIVIL COMMITMENT

According to one survey, 71% of admissions to psychiatric inpatient settings of all types are voluntary.⁴ "Hospitalization is

2. BARRY R. FURROW ET AL., *LIABILITY AND QUALITY ISSUES IN HEALTH CARE* 320 (4th ed. 2001).

3. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

4. Francine Cournos, et al., *Report of the Task Force on Consent to Voluntary Hospitalization*, 21 BULL. AM. ACAD. PSYCHIATRY & L. 293, 293 (1993) (citing

offered voluntarily to decrease the pressures of external responsibility when the patient is overwhelmed by them and to provide structure, a supportive milieu, protection, intensive care, closely supervised pharmacotherapy, electroconvulsive therapy, or other forms of treatment.”⁵

A. *Autonomy, Stigma, and Resources*

Most mental health professionals prefer voluntary admissions to a psychiatric hospital for three primary reasons: (1) a patient who maintains autonomy is more likely to cooperate in treatment, (2) voluntary admission carries less of a stigma than involuntary commitment, and (3) formal proceedings require significant psychiatric and judicial resources.⁶

According to the National Institute of Mental Health, approximately 22% of American adults suffer from a diagnosable mental disorder in a given year,⁷ although half do not seek treatment.⁸ One of the reasons attributed to so many Americans not seeking help is the stigma and fear associated with having a mental illness or mental disorder.⁹

Voluntary admission avoids the stigma associated with a court determination of incompetency.¹⁰ Labeling an individual incompetent can result in being “stigmatized in the eyes of the community” and patients “may come to view themselves in ways that can reinforce and even worsen their impairment.”¹¹ In

Unpublished Data, Client/Patient Sample Survey, National Institute of Mental Health, 1986).

5. THOMAS GUTHEIL T. & PAUL APPELBAUM, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 73 (3d ed. 2000).

6. *Id.* at 47.

7. National Institute of Mental Health, *The Numbers Count: Mental Disorders in America: A Summary of Statistics Describing the Prevalence of Mental Disorders in America*, <http://www.nimh.nih.gov/publicat/numbers.cfm> (last visited Oct. 18, 2005).

8. THE OFFICE FOR SPECIAL POPULATIONS, NAT'L INST. OF MENTAL HEALTH, NATIONAL INSTITUTE OF MENTAL HEALTH FIVE-YEAR STRATEGIC PLAN FOR REDUCING HEALTH DISPARITIES 29 (2001), http://search2.google.cit.nih.gov/search?q=cache:gZw-vFzlyi8J:www.nimh.nih.gov/strategic/healthdisparities.pdf+national+institute+of+mental+health+five-year+strategic+plan&access=p&output=xml_no_dtd&ie=UTF-8&client=NIMH_frontend&site=NIMH&oe=UTF-8&proxystylesheet=NIMH_frontend.

9. *Id.*

10. Paul S. Appelbaum, *Voluntary Hospitalization and Due Process: The Dilemma of Zinermon v. Burch*, 41 HOSP. & COMMUNITY PSYCHIATRY 1059, 1060 (1990).

11. Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL'Y & LAW 6, 41 (1995).

addition, “[t]heir motivation to attempt future behavior in the area in question may be altered in ways that prevent future success, and they may experience serious depression and a damaged sense of psychological well-being.”¹² In fact, “incompetency labeling may itself be psychologically damaging and even disabling . . . [and] may set up a self-fulfilling prophecy that serves to increase and perpetuate the individual’s social and mental health problems.”¹³ Finally, voluntary admission allows for “a stronger alliance with treatment personnel”¹⁴ and eliminates the need for a “costly, time-consuming, and anti-therapeutic”¹⁵ commitment proceeding.

“[T]he idea that the mentally ill might be able to sign themselves into psychiatric hospitals voluntarily is a relatively new one.”¹⁶ Civil rights for mentally ill patients did not gain attention until the 1960s.¹⁷ At that time, patients who were deemed incompetent could be prohibited from writing a will, marrying, disposing of property, entering into contracts, voting, and driving a car.¹⁸ Even today, some of these rights are not entirely available to patients with a past or present mental illness. Voting rights, for example, are still restricted in forty-four states for individuals with certain mental illnesses.¹⁹

Therefore, voluntary admissions were not the norm until the 1970s. At that time, most states incorporated two distinctive features, originating from the District of Columbia, into their commitment law: (1) Patients retain all civil rights upon hospitalization, i.e. are presumed to be legally competent; and (2) patients must be found dangerous to others or themselves before they could be involuntarily committed.²⁰

12. *Id.*

13. *Id.*

14. Appelbaum, *supra* note 10, at 1060.

15. Rael Jean Isaac & Samuel Jan Brakel, *Subverting Good Intentions: A Brief History of Mental Health Law “Reform,”* 2 CORNELL J.L. & PUB. POL’Y 89, 92 (1992).

16. GUTHEIL & APPELBAUM, *supra* note 5, at 46.

17. *Id.* at 94.

18. Isaac & Brakel, *supra* note 15, at 97; *see also* MICHAEL L. PERLIN, LAW AND MENTAL DISABILITY 143 (1994) (according to 1980 NIMH statistics, voluntary patients comprised nearly 42% of all patients admitted to state and county mental hospitals, over 87% of all admitted to private psychiatric hospitals, and over 84% of all those admitted to nonfederal general hospitals for psychiatric services, and, in the aggregate, totaled nearly 840,000 admissions (citing Mental Health, United States, 1983, at 45 (C.A. Taube & S.A Barrett eds., 1985))).

19. Paul S. Appelbaum, “*I Vote. I Count*”: *Mental Disability and the Right to Vote*, 51 PSYCHIATRY SERVICES 849, 849 (2000).

20. Isaac & Brakel, *supra* note 15, at 99.

B. Contra Postion: Commitment Necessary to Protect Rights

Not everyone believes that voluntary admission is preferential. Some reasons offered against voluntary admission include potential for patient abuse, coercion, fewer discharge opportunities, lack of an adversarial process, no attorney representation, and no maximum length of stay.²¹ In addition, it is asserted that, in order to prevent abuse, “states should not allow persons with power of attorney, conservatorship, or guardianship to voluntarily admit a mentally ill person under their care without a formal court review.”²² Finally, it is proffered that consultation with an attorney is essential to ensure voluntary consent and one should be provided to any patient who is considering voluntary admission.²³ Only upon a “thorough interview and investigation” by the attorney that concludes the patient can provide informed consent should voluntary admission be allowed without judicial review.²⁴

According to Brakel, Parry, and Weiner, in 1985, a third-party admission procedure that permits guardians or parents to make commitment decisions should not even be considered a voluntary procedure.²⁵ Similarly, another author believes that “[v]oluntary psychiatric hospitalization should be the result of a competent and informed decision arrived at within a non-coercive environment. Hospitalization based on anything less is not only involuntary, but it is an infringement of personal liberty.”²⁶

Indeed, “one could advance the theory that the proper procedure for patients who are unable to voluntarily consent to hospitalization is involuntary civil commitment.”²⁷ The author is validly concerned that informed consent is necessary to voluntarily admit a patient and that allowing the patient to be voluntarily admitted based on his or her consent without any competency determination leaves too much room for abuse. With the exception of implementing an expiration date requiring a review of voluntary admission status, however, the author’s suggested

21. Donald H. Stone, *The Benefits of Voluntary Inpatient Psychiatric Hospitalization: Myth or Reality*, 9 B.U. PUB. INT. L.J. 25, 28-29 (1999).

22. *Id.* at 33.

23. *Id.* at 34.

24. *Id.* at 35.

25. SAMUAL JAN BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 177 (3d ed. 1985).

26. Stone, *supra* note 21, at 26.

27. *Id.* at 39.

remedies for the problem are not appropriate solutions.²⁸

First, to require attorney involvement for every voluntary inpatient admission would be costly and burdensome to patients and providers. It is also unnecessary. These attorneys would typically lack prior knowledge of the patient or the patient's social or medical history. In addition, a competency determination is hardly something that is within an attorney's professional knowledge.²⁹

Second, a guardian who has already been appointed by a court is an appropriate person to provide informed consent without additional judicial review, at the very least for nonintrusive mental health treatment or admission to a mental health facility. In addition, absent any indication that the patient appointed a health care power of attorney at a time when he or she was incompetent, it defies understanding why the patient's own expressed wishes would not be followed. To the extent, however, that the patient appointed a general power of attorney for financial affairs, the author agrees that he or she should not be permitted to consent to mental health treatment because the patient contemplated financial, not medical, decision-making power.

Finally, it is not in a patient's best interest to be subjected to a formal commitment. Nor is it necessary to require a competency review by an administrative law judge as suggested in those instances when the otherwise voluntary patient is brought to the hospital by family, a care provider, or the police.³⁰ Appropriate safeguards can be implemented without the need to involve the judiciary or formally commit a patient.

While it may be argued that permitting family members or close friends to make medical decisions on behalf of another without judicial approval has the potential for abuse, "the evidence for such abuse is all but nonexistent, and the health care system would slip into paralysis if it had to delay treatment of the large percentage of severely ill patients who are incompetent until a court hearing could be obtained."³¹

28. *See id.* at 42.

29. The United States Supreme Court agrees. *See Youngberg v. Romeo*, 457 U.S. 307, 323 (1982) (according to Justice Blackmun, "there is certainly no reason to think judges or juries are better qualified than appropriate professionals in making [treatment] decisions.").

30. Stone, *supra* note 21, at 41-42.

31. GUTHEIL & APPELBAUM, *supra* note 5, at 226.

IV. COMPETENCY³²

“Competence can be seen as a threshold requirement for persons to retain the power to make decisions for themselves.”³³ Competence can be divided into two categories: legal and clinical.³⁴ Legal incompetence is only declared through a judicial finding that the person is unable to make decisions about his or her own care and welfare.³⁵ Incompetence at this level probably does not pertain to most mentally ill persons.³⁶ A person who cannot at least make and verbalize a treatment decision at some level, as determined by a doctor rather than a judge, is clinically incompetent.³⁷ This person would not have the functional ability to consent to medical or psychiatric care.

Because most mental health professionals favor voluntary admission, “in practice the question of competence is usually ignored.”³⁸ This may be particularly striking to some in light of a 1990 decision by the United States Supreme Court, which raised concerns about voluntary admissions for patients who lacked the capacity to consent.³⁹

A. *Zinermon v. Burch*

Zinermon v. Burch involved procedural due process issues in a civil rights action.⁴⁰ The decision gained attention amongst health

32. For purposes of this article, competency and capacity are used interchangeably. Traditionally the term capacity has been used by physicians whereas competency is a term used in the legal arena. See Cournos et al., *supra* note 4, at 298.

33. GUTHEIL & APPELBAUM, *supra* note 5, at 220.

34. BARBARA A. WEINER & ROBERT M. WETTSTEIN, LEGAL ISSUES IN MENTAL HEALTH CARE 116 (1993).

35. *Id.*

36. *Id.*

37. *Id.*

38. GUTHEIL & APPELBAUM, *supra* note 5, at 48.

39. *Zinermon v. Burch*, 494 U.S. 113 (1990) (5-4 decision).

40. *Id.* Respondent Burch was found wandering along a Florida highway and taken to a private mental health care facility. *Id.* at 118. Upon admission, Burch was hallucinating, confused, and psychotic and believed he was “in heaven.” *Id.* Despite his mental state, he was asked to sign the necessary forms giving consent to admission and treatment. *Id.* He signed the forms and remained at the facility for three days. *Id.* He was diagnosed as having paranoid schizophrenia and given psychotropic medication. *Id.* Needing longer-term care, Burch was transferred to a state hospital. *Id.* He was asked to sign forms requesting admission and authorizing treatment at the state hospital while still at the private facility. *Id.* at 118-19. He then signed additional forms for voluntary admission and treatment

care providers, however, because it discussed at length the appropriateness of voluntarily admitting a patient who lacked capacity to give informed consent.⁴¹ Specifically, Justice Blackmun, the author of the Supreme Court's majority opinion, questioned the practice of admitting a patient voluntarily without first determining the patient's competency to consent to admission or treatment.⁴² The holding of the case, however, did not ultimately decide the issue of whether a competency determination is required.⁴³ Although the Court's comments are merely dicta,⁴⁴ the strong language is hard to ignore.⁴⁵

Justice Blackmun wrote that "[i]t is hardly unforeseeable that a person requesting treatment for mental illness might be incapable of informed consent, and that state officials with the power to admit patients might take their apparent willingness to be admitted at face value,"⁴⁶ resulting in admission of incompetent patients who are willing to sign consent forms.⁴⁷ As a result, the Court determined that the state should have predeprivation procedural safeguards in place in order to protect a patient's liberty interest.⁴⁸ The Court, however, did not specify what those safeguards should

upon arrival at the state hospital. *Id.* at 119. Burch was asked to sign a form authorizing treatment, except electroconvulsive therapy, despite the doctor's progress notes indicating that Burch was distressed, confused, unable to state the reason for his hospitalization, and believed that he was in heaven. *Id.* Subsequent progress notes indicate that Burch was disoriented, semi-mute, confused, bizarre in appearance, uncooperative, extremely psychotic, paranoid, and hallucinating. *Id.* at 119-20. In total, Burch was hospitalized for five months during which time there was no hearing held regarding his hospitalization and treatment. *Id.* at 120.

41. *See generally id.* at 114-39.

42. *Id.* at 135-36.

43. *Id.* at 138-39.

44. *But see*, Isaac & Brakel, *supra* note 15, at 113 (asserting that the Court created an affirmative duty to investigate competency); 53 AM. JUR. 2D *Mentally Impaired Persons, Incompetent Agreement to Voluntary Admission* § 32 (1996) (citing *Zinerman* for the proposition that "[a]n individual who is allowed to sign voluntary consent forms, when he or she is incompetent to consent, states a claim for violation of procedural due process, since the individual is denied the right to receive the procedural safeguards provided in the state's statutory involuntary-placement procedures").

45. "[S]tates and their employees are on notice that to avoid liability they must exercise reasonable professional judgment in making commitment decisions and either must obtain actual informed consent or use involuntary commitment procedures." John Parry, *Involuntary Civil Commitment in the 90s: A Constitutional Perspective*, 18 MENTAL & PHYSICAL DISABILITY L. REP. 320, 325 (1994).

46. *Zinerman*, 494 U.S. at 136.

47. *Id.* at 135.

48. *Id.* at 129.

be.⁴⁹

Finally, although the opinion is based on constitutional law, it leaves open the question of whether its directive, even though *dicta*, applies to patients in a private hospital.⁵⁰ Generally, constitutional protections only apply to actions by government entities (federal, state, and local).⁵¹ Under the state action doctrine, however, “a private entity must comply with the Constitution if it is performing a task that has been traditionally, exclusively done by the government.”⁵² Alternatively, “the Constitution applies if the government affirmatively authorizes, encourages, or facilitates private conduct that violates the Constitution.”⁵³ In other words, the government may have an obligation to stop private infringement of individuals’ basic freedoms, violations of which may be “just as harmful as government violations.”⁵⁴ Either way, at least in Minnesota, it has been recognized that “the primary responsibility for mental health care for people with serious mental illness rests with state government.”⁵⁵ Currently, the literature reflects a difference of opinion whether *Zinermon*’s directive would apply to a private facility.⁵⁶ For the time being, this issue remains

49. “In procedural due process claims, the deprivation by state action of a constitutionally protected interest in ‘life, liberty, or property’ is not in itself unconstitutional; what is unconstitutional is the deprivation of such an interest *without due process of law*.” *Id.* at 125. “[In order] to determine whether a constitutional violation has occurred, it is necessary to ask what process the State provided, and whether it was constitutionally adequate.” *Id.* at 126.

50. A private facility has a duty to make a competency determination. Physicians are required to obtain a patient’s informed consent for medical care. *E.g.*, *Cornfeldt v. Tongen*, 262 N.W.2d 684, 689 (Minn. 1977). If the patient lacks competency, they are unable to consent and the physician will have breached his or her duty of care.

51. ERWIN CHEMEKINSKY, CONSTITUTIONAL LAW 401-02 (2001).

52. *Id.* at 405 (known as the “public functions exception”).

53. *Id.* at 419 (known as the “entanglement exception”).

54. *Id.* at 404.

55. MINN. SUPREME COURT, RESEARCH AND PLANNING OFFICE, STATE COURT ADMINISTRATION, ADVISORY TASK FORCE ON THE CIVIL COMMITMENT SYSTEM 24 (1996) [hereinafter FINAL REPORT].

56. See Paul A. Nidich, *Zinermon v. Burch and Voluntary Admissions to Public Hospitals: A Common Sense Proposal for Compromise*, 25 N. KY. L. REV. 699, 699 (1998) (asserting that *Zinermon* applies to public facilities). *But see* Isaac & Brakel, *supra* note 15, at 113 (asserting that *Zinermon* applies to both public and private facilities by virtue of state law and/or funds in the administration of the state’s mental health system); Karl Menninger, II, *Wrongful Confinement to a Mental Health or Developmental Disabilities Facility*, 44 AM. JUR. 3D *Proof of Facts* § 217 n.70 (2005) (asserting a more middle-of-the-road position that *Zinermon* applies to both state-operated facilities and private facilities that are designated by the state as facilities

unanswered and debatable.

B. Determining Competency

There is no universal definition or method of determining competency.⁵⁷ The quest for an accurate test has been keeping mental health providers and scholars occupied for years. Part of the difficulty is that each patient has his or her own unique mental capabilities. In addition, a patient's mental status can fluctuate in any given day, week, month or year. Nonetheless, even a person with a severe mental illness may be competent to make at least some medical decisions.⁵⁸

After *Zinerman*, an American Psychiatric Association (APA) Task Force was formed, in part, to establish criteria for providers to apply in assessing competency. To preserve the preference of voluntary admissions, "the task force suggested that only a minimal level of capacity be required."⁵⁹ In other words, it "recommended in-hospital administrative decisions (as opposed to full-blown judicial hearings) predicated on easy-to-meet substantive standards."⁶⁰ Specifically, it recommended using two tests for capacity: the ability to communicate choices and the ability to understand relevant information.⁶¹ These tests would be satisfied upon (1) an expression of "agreement with admission and treatment in any way, verbal, behavioral or written," and (2) "displaying [of] some minimal understanding of where [the patient] is and why."⁶²

Since the Task Force's report, a study was conducted to determine whether the APA's criterion was sufficient for patients to comprehend their status and warrant voluntary admission.⁶³ The

that can accept emergency admissions and evaluate the subject persons for involuntary admission).

57. 44 AM. JUR. 3D *Proof of Facts* § 217 (2005).

58. See *Jarvis v. Levine*, 418 N.W.2d 139, 148 n.7 (Minn. 1988); Stephen B. Billick et al., *Competency to Consent to Hospitalization in the Medical Patient*, 25 J. AM. ACAD. PSYCHIATRY & L. 191, 191-96 (1997) (study supporting the position that adult voluntary psychiatric inpatients may retain significant competency even in the face of severe psychiatric illness).

59. GUTHEIL & APPELBAUM, *supra* note 5, at 48.

60. Isaac & Brakel, *supra* note 15, at 115-16.

61. Courmos et al., *supra* note 4, at 300.

62. Isaac & Brakel, *supra* note 15, at 116.

63. Binyamin C. Appelbaum et al., *Competence to Consent to Voluntary Psychiatric Hospitalization: A Test of a Standard Proposed by APA*, 49 PSYCHIATRIC SERVICES 1193 (1998).

study supports the idea that “most patients seeking voluntary hospitalization can pass a low-threshold test of capacity.”⁶⁴ Patients who are initially admitted involuntarily, however, may be “particularly at risk for impaired capacity.”⁶⁵

V. PROCEDURAL SAFEGUARDS

A. *Zinermon Court’s Approach*

The *Zinermon* decision requires “states to have fair procedures for assuring the competency of patients who make decisions to hospitalize themselves.”⁶⁶ The Court did not specify, however, what predeprivation procedural safeguards would be adequate to protect a patient’s liberty interest. “It is unclear whether the Court would actually restrict voluntary hospitalization only to those patients found competent”⁶⁷ The Court noted that protections for due process might include appointment of a guardian advocate to make treatment decisions, and periodic judicial review of placement.⁶⁸ Consequently, the decision leaves the door open for states to decide. Importantly, the decision does not foreclose the possibility of having a family or close friend act as a surrogate in those instances where the patient is unable to consent.

B. *American Psychiatric Association’s Approach*

Early on, the APA took the position that a surrogate or other third party could provide consent on behalf of a voluntary incompetent patient. Prior to *Zinermon*, the APA established guidelines that physicians “obtain, in addition to the consent of the patient, the informed consent of the patient’s *next of kin or guardian*.”⁶⁹ In a post-*Zinermon* review of those guidelines, the Task Force expanded that concept by stating that

[i]nsofar as third party consent to voluntary admission is

64. *Id.* at 1195. *But see* Norman G. Poythres et al., *Capacity to Consent to Voluntary Hospitalization: Searching for a Satisfactory Zinermon Screen*, 24 BULL. AM. ACAD. PSYCHIATRY & L. 439-52 (1996).

65. Appelbaum et al., *supra* note 63, at 1196 (citing Poythres et al., *supra* note 64).

66. BRUCE J. WINICK, THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW 201 (1997).

67. GUTHEIL & APPELBAUM, *supra* note 5, at 48.

68. *Zinermon v. Burch*, 494 U.S. 113, 134 (1990).

69. Cournos et al., *supra* note 4, at 298 (emphasis added).

appropriate and permitted in a given state, it need not be restricted to the next of kin or a guardian. *A third party decision maker could be an individual designated by health care proxy or any other surrogate that the law permits.*⁷⁰

The Task Force also recommended a series of clinical safeguards including “review of voluntariness, appropriateness, and capacity prior to admission and again within 72 hours after hospitalization,” an “intake evaluation” by the third day, development of a “treatment plan,” and “quality assurance mechanisms” such as monitoring by existing quality assurance committees.⁷¹ Finally, “[h]ospitalization should continue only if it is medically necessary.”⁷²

These safeguards are beneficial because (1) they maintain the preference of admitting patients voluntarily, (2) provide an opportunity for a person close to the patient to be involved in treatment decisions, and (3) do not require a formal judicial proceeding. “[A] legislative scheme which encourages voluntary admissions while maintaining appropriate oversight” is ideal.⁷³

VI. THIRD PARTY DECISION MAKERS

A. *Categories*

There are essentially three categories of third party decision makers: (1) those formally appointed by a court (e.g. guardian/conservator), (2) those declared by the patient in an advanced directive (e.g., durable power of attorney for health care), and (3) those permitted to make such decisions (e.g., family members or close friends) with or without existing state law but in no event requiring judicial approval. This section will focus on the third group.

B. *Surrogate Decision-Maker Statutes*

Despite the increasing popularity of advanced directives, many patients fail to execute them, or they may be invalid or inapplicable for a variety of reasons.⁷⁴ To bridge this gap, many states have

70. *Id.* (emphasis added).

71. *Id.* at 302-03.

72. *Id.* at 303.

73. See Nidich, *supra* note 56, at 713.

74. Ardath A. Hamann, *Family Surrogate Laws: A Necessary Supplement to Living*

passed surrogate decision-making or family consent statutes that give family members or other surrogates increased powers to make decisions on behalf of an incompetent person regarding his or her medical treatment.⁷⁵ These statutes “serve to protect medical practitioners from liability for treating an incompetent patient and . . . are intended to preserve the principle of autonomy by authorizing an individual who is most likely to know what decisions the incompetent patient would make to give informed consent on behalf of the incompetent patient.”⁷⁶

At least thirty-four states have enacted surrogate consent statutes.⁷⁷ The term “surrogate decision maker,” however, is not uniformly defined. In some states, a surrogate may only make decisions involving end-of-life decisions.⁷⁸ In others, surrogates are permitted to make medical decisions on behalf of an individual who lacks capacity to consent to treatment based on an order of priority provided by statute.⁷⁹ Still others require court appointment before being permitted to make mental health decisions.⁸⁰ Therefore, it is critical to note that the meaning of the term surrogate may be different depending on the applicable state law.

The following states expressly permit a third person to make at least some decisions for mental health treatment without judicial approval: Arizona, Colorado, District of Columbia, Georgia, Maine, Mississippi, Virginia, and Washington.⁸¹ Other states, including Florida, Illinois, and New Mexico, expressly disallow third parties to make decisions for mental health admissions or treatment.⁸² Still others, such as Minnesota, have very narrow categories of third

Wills and Durable Powers of Attorney, 38 VILL. L. REV. 103, 125-34 (1993).

75. See Practising Law Institute, *Healthcare Decision-Making Training Module*, 75 PRACTISING. L. INST. N.Y. 357, 365 (2000).

76. Adrienne E. Quinn, *Who Should Make Medical Decisions for Incompetent Adults? A Critique of RCW 7.70.065*, 20 SEATTLE U.L. REV. 573, 578 (1997).

77. Practising Law Institute, *supra* note 75, at 447.

78. See, e.g., CONN. GEN. STAT. § 19a-571 (1989).

79. See, e.g., GA. CODE ANN. § 31-9-2 (2001); ME. REV. STAT. ANN. tit. 18-A, § 5-805 (West Supp. 2002).

80. See, e.g., MINN. STAT. § 253B.04, subd. 1b (2004).

81. ARIZ. REV. STAT. ANN. § 36-3231 (West 2003); COLO. REV. STAT. ANN. §§ 15-18.5-103, -14-505 (West 2005); D.C. CODE § 21-2210 (2001); GA. CODE ANN. §§ 31-9-2, -4; ME. REV. STAT. ANN. tit. 18-A, §5-805; MISS. CODE ANN. § 41-41-211 (Supp. 2002); VA. CODE ANN. § 54.1-2986 (Michie 2002); WASH. REV. CODE § 7.70.065 (Supp. 2002).

82. FLA. STAT. ANN. § 765.113 (West 2005); 405 ILL. COMP. STAT. ANN. 5/3-601.2 (West Supp. 1998); N.M. STAT. ANN. § 24-7A-13 (West 2003).

persons who may consent (e.g., health care power of attorney or county agency).⁸³ Many others do not specifically permit or limit decisions for mental health treatment. Of the states that expressly permit a non-judicially appointed third party to consent, none appear to have been challenged on due process grounds. In particular, none have been challenged on the basis that a non-judicially appointed surrogate was an insufficient safeguard to protect the person's rights before admission or treatment for a mental illness.

Typically, statutes provide a list of individuals permitted to act as surrogates and often, but not always, in an order of priority. Those individuals generally include: spouse, parent, child, sibling, and closest living relative. Less common are a close friend, domestic partner, grandparent, grandchild, religious superior, "adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values,"⁸⁴ or a "committee for the patient."⁸⁵ Only Minnesota lists a government agency as an acceptable surrogate.⁸⁶ This is likely because most states recognize that "[g]overnmental and nonprofit health and welfare agencies . . . in fact rarely have the resources or inclination" to act as a surrogate.⁸⁷

1. *One Approach: Washington State*

Washington permits a surrogate decision maker to admit an incompetent patient for mental health treatment and make mental health treatment decisions.⁸⁸ The approved decision makers are listed in order of priority: court-appointed guardian, durable power of attorney for health care, and then spouse, adult children, parents, and adult siblings.⁸⁹ This approach is beneficial to the patient because one of these persons is likely to be available to act in the patient's best interest based on a personal connection with the patient. On the other hand, this approach does not address a situation where someone close to the patient does not fall within

83. MINN. STAT. § 253B.04, subd. 1b.

84. MISS. CODE ANN. § 41-41-211.

85. VA. CODE ANN. § 54.1-2986.

86. MINN. STAT. § 253B.04, subd. 1a.

87. JESSICA W.BERG ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 112 (2d ed. 2001).

88. WASH. REV. CODE § 7.70.065(1).

89. *Id.*

the list or is inappropriately preceded in the order of priority (e.g., an estranged mother would have priority over a sister whom the person sees on a weekly basis).⁹⁰ A surrogate decision-maker statute should allow as much flexibility as possible for determining who is best able to express the patient's wishes.

2. *Use of a Hospital Ethics Committee*

In the event of a dispute or question involving the most appropriate surrogate, a hospital ethics committee may be an appropriate forum for making that determination.⁹¹ If necessary, the committee could be required to consider the following factors:

(1) with whom the incompetent patient resided before becoming incompetent; (2) who of the eligible decision makers was in close contact with the incompetent patient over the years immediately prior to the patient becoming incompetent; (3) who shared an intimate relationship with the patient; (4) who has discussed the patient's wishes concerning medical treatment with the incompetent patient before the patient became incompetent; and (5) who has cared for and will continue to care for the incompetent patient.⁹²

VII. MINNESOTA COMMITMENT ACT

A. *Overview*

The procedures for admission and treatment of a person with a mental illness in Minnesota are contained in the Minnesota Commitment and Treatment Act (the "Act").⁹³ The Act includes procedures for admitting and treating patients voluntarily,⁹⁴ or involuntarily under a civil commitment.⁹⁵ In order to be admitted or treated voluntarily, the patient must give consent.⁹⁶ If the patient is not capable of giving informed consent (i.e., is incompetent), then he or she may be admitted or treated

90. Quinn, *supra* note 76, at 575.

91. *Id.* at 602-03.

92. *Id.* at 605-06.

93. MINN. STAT. ch. 253B (2004).

94. *Id.* § 253B.04.

95. *Id.* § 253B.064-.066, .07-.08.

96. *Id.* § 253B.04, subd. 1.

voluntarily only under very limited conditions.⁹⁷ Patients who fall outside these limited conditions must either be committed or go untreated.

In 1994, a Minnesota Supreme Court Task Force was formed at the request of the legislature to recommend specific changes to the Civil Commitment system. “The Task Force heard testimony that the commitment process is dehumanizing and difficult for proposed patients and families.”⁹⁸ The Task Force also learned that “it is especially difficult to suffer the stigma of Civil Commitment when the person, although incompetent, is not resisting the proposed treatment.”⁹⁹ Further testimony also suggested that “this is particularly true for elderly persons who do not wish to be committed, but for whom due to incapacity there is no other option.”¹⁰⁰

The Task Force established “that a new option, other than Civil Commitment, should be available for persons who are in need of mental health treatment, not resisting treatment, but are incompetent to give informed consent to treatment or admission.”¹⁰¹ The Task Force recommended “that the local mental health authority, or its designee, have the authority to give informed consent on behalf of a person agreeing to [nonintrusive] mental health treatment.”¹⁰²

When the legislature ultimately amended the Voluntary Admission and Treatment Statute, it gave the county the power to consent for a person lacking capacity in the absence of a health care power of attorney.¹⁰³

B. *Mental Illness Defined*

Under the Act, “[a] person with a mental illness may seek or voluntarily agree to accept treatment or admission to a facility.”¹⁰⁴ The term “mental illness” is defined in the Act as an organic

97. *Id.* § 253B.04, subd. 1a (providing that if a person is incapable of giving informed consent, “the designated agency or its designee may give informed consent for mental health treatment or admission to a treatment facility on behalf of the person.”).

98. FINAL REPORT, *supra* note 55, at 35.

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *See* MINN. STAT. § 253B.04 (2004).

104. *Id.* § 253B.04, subd. 1a(a).

disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.¹⁰⁵

This definition includes depression, schizophrenia, and bipolar disorder as well as dementia and Alzheimer's disease. Drug abuse and nicotine dependence, however, are excluded.

C. *Informed Consent*

According to the Act's patients' rights section, "any person who is receiving treatment *or* committed [under the Act],"¹⁰⁶ also "has the right to prior consent to any medical or surgical treatment, *other than treatment for chemical dependency or nonintrusive treatment for mental illness.*"¹⁰⁷ This leaves open the question of what rights, if any, are available to a voluntary patient receiving nonintrusive treatment for a mental illness.¹⁰⁸ Although strangely not providing voluntarily admitted patients with a right to consent to nonintrusive treatment, it is possible to infer such a right from another section of the Act:

A person with a mental illness may seek or voluntarily agree to accept *treatment* or admission to a facility. If the mental health provider determines that the person lacks the capacity to give informed consent for the *treatment* or admission, and in the absence of a health care power of attorney that authorizes consent, the designated agency or its designee may give informed consent for mental health treatment or admission to a treatment facility on behalf of

105. *Id.* § 253B.02, subd. 12a (referring to *id.* § 245.462, subd. 20(a)).

106. *Id.* § 253B.02, subd. 15.

107. *Id.* § 253B.03, subd. 6 (emphasis added).

108. "[This] section does not say that [treatment for chemical dependency or mental illness] may be carried on without prior consent." Eric S. Janus & Richard M. Wolfson, *The Minnesota Commitment Act of 1982: Summary and Analysis*, 6 HAMLINE L. REV. 41, 53 (1983). "Rather, it simply excludes such treatment from the statutory requirement of prior consent. Other sources of law—such as the Constitution or administrative rules and regulations—may well impose consent requirements." *Id.*

the person.¹⁰⁹

Also of note, this section of the Act does not make a distinction between intrusive and nonintrusive treatment for mental illness. Rather, it implies that *all* treatment of a voluntarily admitted patient with mental illness requires consent.

D. Preference of Voluntary Admission Over Civil Commitment

In Minnesota, and in many other states, “[v]oluntary admission is preferred over involuntary commitment and treatment.”¹¹⁰ Prior to 1997, however, Minnesota law did not expressly allow an incompetent person to be admitted voluntarily. The Task Force noted in its 1996 report that, “[i]f a facility knows or should know that the person is incapable of making an informed decision about his or her admission, the facility cannot admit the person as a voluntary patient.”¹¹¹

According to testimony before the House of Representative’s Health and Human Services Committee on the proposed amendments to the voluntary provision, some institutions were refusing to treat persons where there was any doubt of their ability to consent—in some cases this was nearly a categorical refusal to treat a patient voluntarily seeking treatment.¹¹² As a result, the Task Force recommended permitting an alternative method for obtaining consent in order “to make it clearer that voluntary treatment is preferred.”¹¹³ The alternative method chosen by the Task Force was to permit an agency selected by the county board to give informed consent.

E. Competency

When determining capacity to consent to voluntary admission, providers are to use “clinical admission criteria . . . established by the American Psychiatric Association.”¹¹⁴ If a patient is determined

109. MINN. STAT. § 253B.04, subd. 1a (emphasis added).

110. *Id.* § 253B.04, subd. 1; see also Cournos et al., *supra* note 4, at 297.

111. FINAL REPORT, *supra* note 55, at 35 (citing *Zinermon v. Burch*, 494 U.S. 113 (1990)).

112. *Hearing on H.F. 735 Before the H.R. Health and Human Serv. Comm.*, 80th Minn. Leg., Apr. 8, 1997 (audio tape) (statement of Beverly Heydinger, Deputy Attorney General).

113. *Hearing on H.F. 735 Before the H.R. Judiciary Comm.*, 80th Minn. Leg., Apr. 2, 1997 (audio tape) (statement of Beverly Heydinger, Deputy Attorney General).

114. MINN. STAT. § 253B.04, subd. 1.

to lack the capacity to consent, the APA defers to applicable state law to determine who is permitted to consent to admission and treatment.¹¹⁵

The Act defines the specific criteria to be used for determining competency in two circumstances. First, when the county agency is asked to consent to mental health admission or treatment on a patient's behalf, they are asked to apply the following criteria:

- (1) whether the person demonstrates an awareness of the person's illness, and the reasons for treatment, its risks, benefits and alternatives, and the possible consequences of refusing treatment; and
- (2) whether the person communicates verbally or nonverbally a clear choice concerning treatment that is a reasoned one, not based on delusion, even though it may not be in the person's best interests.¹¹⁶

These criteria are similar to that developed by the APA.¹¹⁷ Second, these criteria are also to be used by a court in determining whether a "substitute decision maker" should be appointed to give consent if the designated agency declines or refuses to do so.¹¹⁸

F. Third Party Decision Makers

Minnesota does not have a surrogate decision-maker statute nor does state common law directly provide for a non-judicially appointed surrogate to give informed consent for mental health admission or treatment. The persons who have been expressly given the authority to consent for a voluntarily admitted patient are narrowly defined in Minnesota Statutes section 253B.04 (the "Voluntary Admission and Treatment Statute") and Minnesota Statutes section 253B.092 (the "Neuroleptic Medication Statute"). Except in the case of neuroleptic medication, without judicial approval, the law only permits guardians, health care power of attorneys, and county agencies to consent to voluntary admission and treatment for mental illness.¹¹⁹ If none of these persons are available to consent, the court must appoint a "substitute decision

115. See Cournos et al., *supra* note 4, at 298.

116. MINN. STAT. § 253B.04, subd. 1a(b); see also *id.* § 253B.092, subd. 5.

117. See Cournos et al., *supra* note 4, at 298.

118. MINN. STAT. § 253B.04, subd. 1b.

119. *Id.* § 253B.04, subd. 1a(a). Note, however, section 253B.04, subdivision 1b below regarding guardian consent for admission to a treatment facility.

maker.”¹²⁰ Notably, providers who treat an incompetent patient are only given statutory immunity from civil or criminal liability when they rely on the consent of a designated agency or court-appointed substitute decision maker.¹²¹

In the case of neuroleptic medication, only a health care power of attorney (or proxy), court-appointed substitute decision maker, or a health care provider in an emergency, may give consent when a patient lacks capacity.¹²²

Understandably, Minnesota law provides more protection for patients undergoing “intrusive therapy.” Under the Act, “‘intrusive mental health treatment’ means electroshock therapy and neuroleptic medication and does not include treatment for mental retardation.”¹²³ The Act does not define the term “nonintrusive treatment;” however, based on the definition of intrusive therapy above, nonintrusive treatment is likely to include such things as psychotherapy and certain medications. The following provisions related to third party consent are separated into two sections: admission and treatment that is nonintrusive and treatment that is intrusive.

1. Health Care Power of Attorney

Under the Voluntary Admission and Treatment Statute, a health care power of attorney may consent to mental health treatment or admission to a treatment facility.¹²⁴ Individuals may designate a health care power of attorney in an advanced directive to make decisions in the event that they become incompetent.¹²⁵ Individuals may make a specific declaration directing the health care power of attorney as to how treatment decisions should be made when intrusive mental health treatment is required (i.e., electroshock therapy and neuroleptics).¹²⁶ In the absence of a specific declaration, the health care power of attorney is generally authorized to make those decisions.

The advance directive statutes were intended to help alleviate the problem of having no one to provide consent on a patient’s

120. *Id.* § 253B.04, subd. 1b.

121. *Id.* § 253B.04, subd. 1a(d).

122. *Id.* § 253B.092, subd. 2.

123. *Id.* § 253B.03, subd. 6b.

124. *Id.* § 253B.04, subd. 1a.

125. *Id.* § 145C.02.

126. *Id.* § 145C.05, subd. 2(6).

behalf. Unfortunately, many patients are without advance directives appointing a health care power of attorney. In the hospital, providers are required to inform patients of their ability to prepare advance directives.¹²⁷ Whether that information comes too late, or the patient is not sufficiently encouraged to undertake the effort or some other reason, only a small number of patients have advance directives.

2. “Designated Agency”

In the absence of a health care power of attorney, a “designated agency” may consent to admission or mental health treatment for a patient lacking capacity to consent.¹²⁸ A “designated agency” is defined as “an agency selected by the county board to provide the social services required” under the Act.¹²⁹ The Minnesota Supreme Court Task Force originally recommended that local mental health facilities have the authority to provide consent “if the local mental health authority gives informed consent on behalf of the person, and the person does not refuse treatment, the treatment is allowed.”¹³⁰ The Task Force’s report does not explain why it recommended the local mental health authority, rather than a surrogate decision maker such as family, friends, and/or an independent medical provider or care team. There is also no indication that the counties were provided additional resources or training to fulfill this obligation. Furthermore, the authority given to the counties is permissive, not required. Therefore, when the county fails or refuses to consent, the court must appoint a substitute decision maker.

3. Guardians

Under the Uniform Probate Code, as adopted in Minnesota, courts have the power to appoint a guardian to “consent . . . to receive necessary medical or other professional care, counsel, *treatment or service*, except . . . consent for psychosurgery, electroshock, sterilization, or experimental treatment of any kind” on behalf of the ward or conservatee.¹³¹

127. *Id.* § 253B.03, subd. 6b.

128. *Id.* § 253B.04, subd. 1a(a).

129. *Id.* § 253B.02, subd. 5.

130. FINAL REPORT, *supra* note 55, at 35.

131. MINN. STAT. § 524.5-313(c)(4)(i) (emphasis added). Minnesota adopted

Initially, the Voluntary Admission and Treatment Statute provided only that a health care agent or “designated” agency could give consent on behalf of a patient who lacked capacity. In other words, while it appeared under the guardianship provisions that a guardian could consent to admission and treatment for mental illness, the Act did not extend such authority. As further indication that the Act did not permit guardians to give consent, the Legislature added a provision in the 2001 Special Session permitting the court to appoint a “substitute decision maker” if the county refuses or declines to provide consent.¹³² A substitute decision maker is not defined in the Voluntary Admission and Treatment Statute, but it would presumably include a guardian.

In 2004, the Legislature added a new section in the Voluntary Admission and Treatment Statute stating that incompetent patients who were voluntarily participating in treatment for a mental illness were not subject to commitment if a guardian or conservator gave informed consent.¹³³ However, the Legislature did not revise a later section providing that only a health care agent or designated agency in the absence of a health care agent, could consent to admission and treatment for a person who lacks capacity.¹³⁴ Therefore, health care providers are left with uncertainty as to whether they may obtain consent from a guardian who has not been appointed a substitute decision maker. It only makes sense that a judicially appointed guardian should be able to consent to admission and treatment for a person with a mental illness; however, the Legislature needs to make that clear. It would be repetitive and unnecessary to require family or friends to go to court a second time to be appointed as a substitute decision maker.

In addition, the Legislature repealed the powers of a conservator to make any medical decisions earlier in the session.¹³⁵ Therefore, the reference to conservators should be removed, or clarified to indicate that it applies only to conservators who had the authority to consent to mental health treatment prior to the effective date of the new provision of the Uniform Probate Code.

the Uniform Probate Code in 2003. Previously, this language applied to both guardianships and conservatorships. The new section describing a conservator’s powers does not contain this language. *Id.* § 524.5-417.

132. *Id.* § 253B.04, subd. 1b.

133. *Id.* § 253B.04, subd. 1.

134. *Id.* § 253B.04, subd. 1a.

135. *See supra* note 131.

4. “Substitute Decision Makers”

In the 2001 special legislative session, the legislature added a provision to the Voluntary Admission and Treatment Statute allowing a “substitute decision maker” to consent to treatment when the designated agency declines.¹³⁶ A “substitute decision maker” is not a term defined in either the general definition section of the Act or in the Voluntary Admission and Treatment Statute. The term appears to have been adopted from the Neuroleptic Medication Statute enacted in 1997.¹³⁷

A substitute decision maker must be appointed by the court.¹³⁸ If an incompetent patient does not have a health care power of attorney, and the designated agency declines to consent on the patient’s behalf, a family member, friend, conservator, or possibly even a guardian must petition the court before the patient can be admitted or treated. The duties of a “substitute decision maker” are not defined in the Act. According to testimony in support of the bill adding the provision in the Neuroleptic Medication Statute, the “substitute decision maker” is called upon “to make a judgment as to what [the competent] person would have intended and what is in their best interest if their intent can’t be discerned.”¹³⁹

5. *Neuroleptic Medication Exception*

In 1997, the Minnesota Legislature enacted a new process for the administration of neuroleptic medications to voluntarily admitted patients.¹⁴⁰ The subdivision regarding voluntary treatment or admission for persons with mental illness specifically provides that it “does not authorize the administration of neuroleptic medications.”¹⁴¹ Rather, “[n]euroleptic medication may be administered *only* as provided in section 253B.092.”¹⁴² Under that section, neuroleptic medication may be administered to a patient who lacks capacity,¹⁴³ without judicial review [only] (1)

136. MINN. STAT. § 253B.04, subd. 1b.

137. *Id.* § 253B.092.

138. *Id.* § 253B.04, subd. 1b.

139. *Hearing on H.F. 2566 Before the H.R. Judiciary Comm.*, 80th Minn. Leg., Jan. 29, 1996 (audio tape) (statement of Beverly Heydinger, Deputy Attorney General).

140. MINN. STAT. § 253B.092, subd. 1. The process is also the same for patients who are the subject of a petition for early intervention or commitment. *Id.*

141. *Id.* § 253B.04, subd. 1a(f).

142. *Id.* (emphasis added).

143. The statute does not indicate how or by whom the determination of capacity is to be made in the *absence of* judicial review. “In determining a person’s

with consent of a health care agent or proxy according to the patient's health care directive;¹⁴⁴ (2) with the consent of a substitute decision maker appointed by the court *and* the patient is not refusing the medication;¹⁴⁵ or (3) by a treating physician in an emergency situation, "for so long as the emergency continues to exist, up to 14 days," even if the patient refuses.¹⁴⁶

There are several inconsistencies within this section of the statute. First, it lists the options in such a way as to give the impression that they each have equal authority.¹⁴⁷ In fact, according to the bill of rights section, if the incompetent person has appointed a health care agent or proxy in a mental health directive to make decisions regarding intrusive treatments, those directives "*must*" be followed.¹⁴⁸ A physician who wants to act contrary to a directive of a noncommitted person may do so only if he or she is committed and a court order authorizes the treatment.¹⁴⁹ Therefore, item two, and possibly even three, above should be permissible only in the absence of a directive.

Second, the Act states that "the court shall *give preference* to a guardian or conservator, proxy, or health care agent with authority to make health care decisions for the patient" when appointing a substitute decision maker.¹⁵⁰ This presents two issues. As already mentioned, the Act otherwise requires that a patient's directive regarding intrusive therapies "*must*" be followed.¹⁵¹ Provided that is true, it is unnecessary for the court to "give preference" to a health care agent because the agent has already been designated by the

capacity to make decisions regarding the administration of neuroleptic medication, *the court shall consider . . .*" *Id.* § 253B.092, subd. 5(b) (emphasis added).

144. *Id.* § 253B.092, subd. 2(2). Note that this section does not specifically state what should be done if the patient refuses the medication during the time that the agent or proxy have power to consent. If the health care directive specifically stated that medication could be administered even in the event that the patient refuses while lacking capacity, then it would probably make sense to go ahead. It is not so clear when the patient does not provide direction under the health care directive as to what should be done if they refuse. *See also id.* § 253B.092, subd. 7(b).

145. *Id.* § 253B.092, subd. 2(3).

146. *Id.* § 253B.092, subd. 2(4), subd. 3. Medication may be administered after the 14 days "[i]f a request for authorization to administer medication is made to the court" during that time. *Id.* § 253B.092, subd. 3.

147. *See id.* § 253B.092, subd. 2.

148. *Id.* § 253B.03, subd. 6b (emphasis added).

149. *Id.* § 253B.03, subd. 6d(d).

150. *Id.* § 253B.092, subd. 6(a) (emphasis added).

151. *Id.* § 253B.03, subd. 6b (emphasis added).

patient. In fact, if there were a health care agent, there would appear to be no need for the court to appoint a substitute decision maker in the first place.

In addition, this section indicates that the court shall also “give preference to a guardian or conservator” when appointing a substitute decision maker to consent to administration of neuroleptics.¹⁵² In 1996, in *In re Conservatorship of Foster*, the Minnesota Supreme Court held that a conservator (and presumably a guardian) given the power to consent to necessary medical care could consent to administration of neuroleptics without seeking prior court approval.¹⁵³ The Uniform Probate Code automatically grants court-appointed guardians the power to consent to necessary medical care.¹⁵⁴ The list of exceptions does not include neuroleptics. Now that the Neuroleptics Medication Statute provides that a court should “give preference” to a guardian or conservator when appointing a substitute decision maker, it appears that the legislature intended to supersede the *Foster* court’s decision when the Act was amended in 1997.

G. Summary

Minnesota mental health providers are faced with limited choices for admitting and treating an incompetent patient with a mental illness. The Act does not clearly define who may consent to either admission or treatment for an incompetent patient and under what circumstances. While it may be argued that the existing statutory provisions are merely safe harbors, given the extensively laid out (although somewhat difficult to follow) procedures, providers should be wary of deviating far from them. On the other hand, if health care providers strictly comply with the existing statutory provisions, patients will be forced unnecessarily into the court system and treatment will be delayed.

While advanced directive provisions sufficiently permit a patient to make decisions while competent, in reality, most patients have not prepared such documents. Minnesota should therefore adopt a process that would allow, within specific constraints, someone close to the patient to act as a surrogate decision-maker

152. *Id.* § 253B.092, subd. 6(a).

153. 547 N.W.2d 81, 88 (providing that a multidisciplinary treatment review panel must also give written approval).

154. *See* MINN. STAT. § 524.5-313(c)(4)(i).

without having to go to court.

IX. CONCLUSION

Everyday, family members are permitted to consent on an incompetent patient's behalf for surgery and other medical treatment unrelated to mental health. Mental illness is a medical condition that should not require an inflexible, formal judicial process in order to treat an incompetent patient.

In *Zinerman*, the Supreme Court suggested implementing safeguards to protect a patient's liberty interests rather than requiring involuntary commitment for incompetent patients.¹⁵⁵ Minnesota law permits, and purports to encourage, voluntary admission for incompetent patients. The Minnesota Commitment Act should be revised to provide less formal and more flexible procedures that would permit family or friends to consent to treatment of an incompetent patient while at the same time, maintain oversight based primarily on a non-judicial system.

155. *Zinerman v. Burch*, 494 U.S. 113, 135-36 (1990).