Disclaimer about this presentation

• Nothing in this presentation replaces legal advice, and is only intended as a guide to walk you through the process so you can make the best decisions for you and your situation.

• It is meant to help you understand what a mental health advance directive is and is not.

• If you have legal questions about a mental health advance directive, please consult a lawyer.

This presentation is sponsored by the Spokane County Behavioral Health (Administrative Services Organization).
Mental Health Advance Directives

Part Three: Writing Your Directive
Writing Your Directive

• **Think it through**
  - This is an important document that is meant to share your wishes during a crisis situation when you may not be able to share them yourself.
  - Take your time and think through what you want in your mental health advance directive.
  - Make sure your wishes are clearly written and easy to understand.

• **Involving others**
  - If you are looking for help writing your mental health advance directive, make sure the people you ask are those you trust and know will listen to your wishes.
  - Involve others who will support you in writing a mental health advance directive and will refrain from sharing their opinion unless asked.
Finding the Right Person(s) to Help Write Your Mental Health Advance Directive

• Pick someone who will:

  • Listen and ask questions.

  • Take the time needed to fully complete your mental health advance directive.

  • Help you gather information and other people who may be helpful throughout the process.

  • Assist in identifying pros and cons to the choices being made.

  • Help you understand your rights.

It’s important to watch for someone to help who may have a conflict of interest. A behavioral health provider cannot be your agent, and certain family members cannot sign as witnesses.
Finding the Right Person(s) to Help Write Your Mental Health Advance Directive

• Within your mental health advance directive, there are people who you may want to do things for you, such as act as your agent, take care of children or pets, or let certain people know you are in crisis.

• Be sure to give each person that you want to do something a copy of your mental health advance directive.

• It is also important that each person agrees with what you have asked of them and are willing to take on those activities.
The Mental Health Advance Directive Form
Preparing to Start Your Mental Health Advance Directive

• Make sure to thoroughly read through the Mental Health Advance Directive form in its entirety before you begin. It may be helpful to have several copies of the form so that you can practice what you want to say before you make it official.

• It might be helpful to read RCW 71.32 in its entirety to understand more about what your mental health advance directive can and can’t do for you.

• If you have a hard time understanding all of RCW 71.32, ask someone to help you who can explain “legalese” and can help put these parts in plain language for you.
Part III: When This Directive is Effective

This section of the mental health advance directive must be completed for it to be valid.

• You may decide to have your mental health advance directive effective:
  • Immediately upon signature
  • If you become incapacitated
  • When the following circumstances, symptoms or behaviors occur – You may list what must occur for it to be active.

• There are pros and cons to each choice, be mindful when making this decision.

PART III

WHEN THIS DIRECTIVE IS EFFECTIVE

YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.

I intend that this directive become effective (YOU MUST CHOOSE ONLY ONE): _________Immediately upon my signing of this directive.

_______If I become incapacitated.

_______When the following circumstances, symptoms, or behaviors occur:

________________________________________________________________________

________________________________________________________________________
Part IV:
Duration of this Mental Health Directive

You must complete this part for this directive to be valid.

- When deciding the duration of your mental health advance directive, there are two options provided on the form:
  - Remain valid and in effect for an indefinite period of time.
  - Automatically expire ______ years from the date if was created.

Keep in mind that you can revoke your mental health advance directive at any time, regardless of which option you choose.
Part V: When I May Revoke This Directive

• There are two options to think about when deciding when you want to be able to revoke your mental health advance directive:

  • **Only when I have capacity**
    • This option means that your mental health advance directive can only be revoked when it is deemed that you have capacity. If this option is chosen, your mental health advance directive will be in effect when you are incapacitated and you may receive treatment that is specified in the directive, **even if you object to the treatment at the time.**

  • **Even if I am incapacitated**
    • This option means that your mental health advance directive can be revoked even when you are deemed to be incapacitated. Incapacitated is defined as being found to not to be able to understand your choices and make decisions.

You must choose one of these options or none of your mental health advance directive will be followed by professionals.
Part V: Preferences & Instructions about Treatment, Facilities and Physicians, Physician Assistants, or Advanced Registered Nurse Practitioners (Sections A & B)

• In this section, you can choose who you want contacted when your mental health advance directive is in effect. This includes physicians and any other providers that you feel have an impact on your mental health care.

  • Examples: Clinician/therapist, peer support specialist, case manager, psychiatrist, medical doctor, etc.

  • The form contains areas for you to list who you want to be contacted as well as their profession and contact information. This allows the facility providing care to have all the information they need to ensure that the people you want involved in your care are contacted.
Part V: Preferences & Instructions about Treatment, Facilities, Physicians, Physician Assistants, and Advanced Registered Nurse Practitioners (Section C)

- Preferences and instructions about medications for psychiatric treatment, including preferences and allergies.

- On the right, you will see a copy of the options for medication preferences.

  - You can choose specific medications that you are comfortable with and specific medications that you are not comfortable with.

  - You can also include information about your wishes regarding taking medications with specific side effects.

  *It may be helpful to seek assistance from your prescriber when working on this section.*
Part VI: Preferences and Instructions about Treatment, Facilities, Physicians, Physician Assistants, and Advanced Registered Nurse Practitioners (Section D)

- This section includes information regarding hospitalization and alternatives. In this section, you can rank the options (1 - for first choice, 2 – second choice and so on).
  - Calling someone or having someone call when needed
  - Staying overnight with someone.
  - Having a mental health service provider come to see you.
  - Going to crisis triage or an emergency room
  - Staying overnight in a crisis respite bed (meaning temporary bed to get away from stressors).
  - Seeking a service provider to help with psychiatric medications.
  - Other: please specify

Before completing this section, make sure to talk with anyone identified, so that they understand and are willing and able to provide what you want them to provide.
Part VI: Preferences and Instructions about Treatment, Facilities, Physicians Physician Assistants, and Advanced Registered Nurse Practitioners (Section D)

Authority to consent to inpatient hospitalization

• By choosing **option 1**, you agree to let your agent give consent to hospitalization on your behalf, with the agreement of a doctor and the admitting hospital.

  1. Authority to Consent to Inpatient Treatment

     I consent, and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for _______ days (not to exceed 14 days)

     (Sign one):

     ______ If deemed appropriate by my agent (if appointed) and treating physician, -

     physician assistant, or advanced registered nurse practitioner.

     (Signature)

     OR

     ______ Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization) ______________________

     _________________________________

     (Signature)

     OR

     ______ I do not consent, or authorize my agent (if appointed) to consent, to inpatient treatment.

     (Signature)

• By choosing **option 2**, you are agreeing that you can be hospitalized if you are behaving in a certain way, including symptoms that are a sign that you need to go to the hospital. Note that the hospital does not have to agree to admit you when you show these symptoms.

• By choosing **option 3**, you are deciding not to give your agent the power to admit you to a hospital and not to provide consent in advance to hospitalization.
Part VI: Preferences and Instructions about Treatment, Facilities, Physicians, Physician Assistants, and Advanced Registered Nurse Practitioners (Section D)

• You may also include instructions in your mental health advance directive about what hospitals you would like to go to if hospitalization is needed.

• You may state specific hospitals you would like to go to, or that you are NOT comfortable with going to specific hospitals.

*Note that in some emergency situations, or if there is limited space, you will not necessarily be taken to the hospital you choose*
Part VI: Preferences and Instructions about Treatment, Facilities and Physicians, Physician Assistants, Advanced Registered Nurse Practitioners (Section E)

• Preferences and instructions regarding a pre-emergency situation.

  • In this section you can list interventions that may be tried before using seclusion or restraint to be considered.

  • This may be helpful information for staff so that they can attempt other interventions to calm you down before resorting to seclusion and restraint.

  • Note that hospital staff are not required to follow your wishes in this section or the next but, they are required to read your mental health advance directive and consider your choices.

E. Preferences and Instructions About Pre-emergency

I would like the interventions below to be tried before use of seclusion or restraint is considered (initial all that apply):

_____ "Talk me down" one-on-one
_____ More medication
_____ Time out/privacy
_____ Show of authority/force
_____ Shift my attention to something else
_____ Set firm limits on my behavior
_____ Help me to discuss/vent feelings
_____ Decrease stimulation
_____ Offer to have neutral person settle dispute
_____ Other, specify ________________________________
Part VI: Preferences and Instructions about Treatment, Facilities, Physicians, Physician Assistants, and Advanced Registered Nurse Practitioners (Section F)

• In section F, you may rate your choices regarding seclusion, restraint and emergency medications (1 – first choice, 2 - second choice and so on).

• Note that hospital staff are not required to follow your wishes in this section but, they are required to read your mental health advance directive and consider your choices.

### F. Preferences and Instructions About Seclusion, Restraint, and Emergency Medications

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen (choose “1” for first choice, ”2” for second choice, and so on):

- Seclusion
- Seclusion and physical restraint (combined)
- Medication by injection
- Medication in pill or liquid form

In the event that my attending physician decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part III C of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.
Part VI: Preferences and Instructions about Treatment, Facilities, Physicians, Physician Assistants, and Advanced Registered Nurse Practitioners (Section G)

• It is important to make sure you fully understand what you are agreeing to or not agreeing to in this section. To find out more, you can talk to your physician or do some research on your own and discuss it with others to make sure the information you found is accurate.

G. Preferences and Instructions About Electroconvulsive Therapy (ECT or Shock Therapy)

My wishes regarding electroconvulsive therapy are (sign one):

[ ] I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy.

(Signature)

[ ] I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

(Signature)

[ ] I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions: 

(Signature)
Part VI: Preferences and Instructions about Treatment, Facilities, Physicians, Physician Assistants, and Advanced Registered Nurse Practitioners (Section H-I)

- In section H, you may choose if there are certain people who you do NOT want to visit you while hospitalized.
- In section I, you can include additional instructions about your behavioral health care, including emergency contacts, ways to avoid hospitalization, how you react to hospitalization, and what staff can do to help you in a crisis.

H. Preferences and Instructions About Who is Permitted to Visit

If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name: __________________________

Name: __________________________

Name: __________________________

I understand that persons not listed above may be permitted to visit me.

I. Additional Instructions About My Mental Health Care

Other instructions about my mental health care:

________________________________________

________________________________________

In case of emergency, please contact:

Name: __________________________ Address:

Work telephone: ______ | _______ Home telephone: ______

Physician: __________________________ Address:

Telephone: __________________________

The following may help me to avoid a hospitalization:

________________________________________

I generally react to being hospitalized as follows:

________________________________________

Staff of the hospital or crisis unit can help me by doing the following:

________________________________________
Part VI: Preferences and Instructions about Treatment, Facilities and Physicians (Section J)

• Refusal of treatment
  • In this section, you may choose to refuse behavioral health treatment.

*Note that if you refuse consent to any treatment, you may still be treated if you are hospitalized under the Involuntary Treatment Act (Revised Code of Washington 71.05) or in the event that there is an emergency.*
Part VII: Durable Power of Attorney (Appointment of my Agent) (Part A)

Only fill out this section of the mental health advance directive if you wish to appoint or nominate an agent or guardian.

- As stated earlier in this presentation, an agent can help you make sure that your mental health advance directive is followed. Refer to Part 2 of this PowerPoint series for more information about appointing an agent.

- An agent can also make decisions for you when you are incapacitated (or have capacity if you so choose).

PART VII.

DURABLE POWER OF ATTORNEY (APPOINTMENT OF MY AGENT)
(Fill out this part only if you wish to appoint an agent or nominate a guardian.)

I authorize an agent to make mental health treatment decisions on my behalf. The authority granted to my agent includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service, or procedure, consistent with any instructions and/or limitations I have set forth in this directive. I intend that those decisions be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document and my agent does not otherwise know my wishes, I authorize my agent to make the decision that my agent determines is in my best interest. This agency shall not be affected by my incapacity. Unless I state otherwise in this durable power of attorney, I may revoke it unless prohibited by other state law.

HIPAA Release Authority. In addition to the other powers granted by this document, I grant to my Attorney-in-Fact the power and authority to serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended from time to time, and its regulations. My Attorney-in-Fact will serve as my “HIPAA personal representative” and will exercise this authority at any time that my Attorney-in-Fact is exercising authority under this document.

A. Designation of an Agent

I appoint the following person as my agent to make mental health treatment decisions for me as authorized in this document and request that this person be notified immediately when this directive becomes effective:

Name: __________________________ Address: __________________________
Work telephone: __________________ Home/ cellphone: __________________
Relationship: ____________________
Part VI: Durable Power of Attorney
(Appointment of my Agent) (Part B-C-D)

• In Part B, you can name an alternate agent in case the original agent is not available, or if you have revoked that agent and are naming the alternate agent to help make decisions.

• In Part C, you can choose to limit your agent’s authority. There may be decisions that you are not comfortable with your agent making for you.

• You may also limit your own ability to revoke the Power of Attorney in Part D. For example, you may not allow yourself to revoke the Power of Attorney if you are incapacitated.

B. Designation of Alternate Agent

If the person named above is unavailable, unable, or refuses to serve as my agent, or I revoke that person’s authority to serve as my agent, I hereby appoint the following person as my alternate agent and request that this person be notified immediately when this directive becomes effective or when my original agent is no longer my agent:

Name: ___________________ Address: ________________________________
Work phone: ______________ Home phone: _________________________
Relationship: ____________________________

C. Limitations on My Agent’s Authority

I do not grant my agent the authority to consent on my behalf to the following:

__________________________________________

__________________________________________

D. Limitations on My Ability to Revoke this Durable Power of Attorney

I choose to limit my ability to revoke this durable power of attorney as follows:

__________________________________________

__________________________________________
Part VII: Durable Power of Attorney (Appointment of my Agent) (Part E)

- Preference on a court ordered guardian

  - By filling out this section, you are NOT agreeing to have a guardian.

  - This section, if you choose to fill it out, allows you to say who you would like to be your guardian, IF a court decides you need one. Note that if the court has "good cause" for not appointing that person to be your guardian, they do not have to follow your recommendation.

  - This part may be helpful if you are worried about someone you do not like or trust becoming your guardian.

When choosing someone to be your guardian if a court deems you need one, make sure that whoever you list here is willing to take on the activities associated with being a guardian before completing this part of your mental health advanced directive.

E. Preference as to Court-Appointed Guardian

In the event a court appoints a guardian who will make decisions regarding my mental health treatment, I nominate my then serving agent (or name someone else as my guardian):

Name and contact information (if someone other than agent or alternate agent):

Name: ______________________ Address: ______________________

Work phone: ______________ Home phone: ______________

Relationship: ______________________

The appointment of a guardian of my estate or my person or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as authorized by law.

________________________________________
(Signature required if nomination is made)
Part VIII: Other Documents

- In this section, you can state if you have other legal documents regarding your healthcare services.

- It may be important for people in charge of your behavioral health treatment to know about these documents so that they are contacting the people you wish to be contacted.

**PART VIII.**

**OTHER DOCUMENTS**

*(Initial all that apply)*

I have executed the following documents that include the power to make decisions regarding health care services for myself:

- [ ] Health care power of attorney (chapter 11.125 RCW)
- [ ] "Living will" (Health care directive; chapter 70.122 RCW)
- [ ] I have appointed more than one agent. I understand that the most recently appointed agent controls except as stated below:
Part IX: Notifications of Others and Personal Affairs (Part A-C)

- In this section you have the opportunity to provide non-treatment instructions for hospital staff.

- This includes:
  - Additional people you would like to be notified of the hospitalization. This includes space for names and contact information.
  - Additional instructions about personal affairs while admitted to a behavioral health treatment facility (examples: finances/bills, care of pets, care of dependents/children, etc.).
  - Part C allows for additional instructions and preferences if there is something that you have not yet gotten to specify within your mental health advance directive.

PART IX.

NOTIFICATION OF OTHERS AND CARE OF PERSONAL AFFAIRS
(Fill out this part only if you wish to provide nontreatment instructions.)

I understand the preferences and instructions in this part are **NOT** the responsibility of my treatment provider and that no treatment provider is required to act on them.

A. **Who Should Be Notified:**

I desire my agent to notify the following individuals as soon as possible when this directive becomes effective.

Name: ___________________________ Address: ___________________________

Day telephone: ___________________ Evening telephone: ___________________

Name: __________________________ Address: ___________________________

Day telephone: ___________________ Evening telephone: ___________________

B. **Preferences or Instructions About Personal Affairs**

I have the following preferences or instructions about my personal affairs (e.g., care of dependents, pets, household) if I am admitted to a mental health treatment facility:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

C. **Additional Preferences and Instructions:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Part X. Signature

If the directions are not accurately followed while signing your mental health advance directive, it may not be valid.

- Make sure to read ALL instructions before signing your mental health advance directive.

- We encourage people to get this document notarized at the time of signature.
Part X. Signature

• You can elect not to have your mental health advance directive notarized. In this case, you must have two people witness your directive.

• There are rules about who can witness your mental health advance directive.

• They cannot:
  • Be someone who can make medical decisions on your behalf.
  • Be someone directly involved with your care.
  • Be an owner or operator of a facility where you live or are being treated.
  • Be related to you by blood, marriage or in a dating relationship.
  • Be an incapacitated person,
  • Someone who benefits financially if you go into treatment.
  • Be a minor.

OR

This directive was signed and declared by the "Principal," to be his or her directive, in our presence who, at his or her request, have signed our names below as witnesses. We declare that, at the time of the creation of this instrument, the Principal is personally known to us, and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:

(A) A person designated to make medical decisions on the principal’s behalf;
(B) A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed;
(C) An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident;
(D) A person who is related by blood, marriage, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 26.50.010;
(E) An incapacitated person;
(F) A person who would benefit financially if the principal undergoes mental health treatment; or
(G) A minor.

Witness 1: Signature: ___________________________ Date: _______________
Printed Name: _______________________________________________________
Telephone __________________ Address _____________________________________

Witness 2: Signature: ___________________________ Date: _______________
Printed Name: _______________________________________________________
Telephone __________________ Address _____________________________________
Part XI. Record of Mental Health Advance Directive

• In this part, you list the people that have copies of your mental health advance directive. Some people to consider:
  • Your agent/guardian if one is appointed
  • Spouse or close family members
  • Anyone mentioned or tasked with activities within your mental health advance directive
  • Primary Care Physician
  • Primary Mental Health Clinician
  • Mental Health Case Manager
  • Peer Support Specialist
  • Attorney or Probation Officer, if applicable

<table>
<thead>
<tr>
<th>PART XI.</th>
</tr>
</thead>
<tbody>
<tr>
<td>RECORD OF DIRECTIVE</td>
</tr>
<tr>
<td>I have given a copy of this directive to the following persons:</td>
</tr>
<tr>
<td>Name: ______________________ Address: ______________________</td>
</tr>
<tr>
<td>Day telephone: ___________ Evening telephone: _____________</td>
</tr>
</tbody>
</table>

| Name: ______________________ Address: ______________________ |
| Day telephone: ___________ Evening telephone: _____________ |
Part XII: Revocation of This Directive

• At the end of your mental health advance directive, there is a place where you can revoke your directive.

• You may either revoke the whole document, or only specific parts.

• For example, if you no longer want a specific person to be your agent, you may choose to only revoke that part of the directive.

Do not sign this part unless you intend to revoke your directive in part, or in whole.
Mental Health Advance Directives

End of Part Three
Contact Information for Spokane Regional Behavioral Health Ombuds

• Phone: 509-477-4666

• Toll Free: 1-866-814-3409

• Email: SCRBHombuds@spokanecounty.org

• Fax: 509-477-4667