SENATE BILL REPORT
ESSB 6589

As Passed Senate, February 19, 2002

Title: An act relating to mental health advance directives.

Brief Description: Authorizing mental health advance directives.

Sponsors: Senate Committee on Human Services & Corrections (originally sponsored by Senators Keiser and Long).

Brief History:
Committee Activity: Human Services & Corrections: 1/30/02, 2/7/02 [DPS].
Passed Senate: 2/19/02, 46-1.

SENATE COMMITTEE ON HUMAN SERVICES & CORRECTIONS

Majority Report: That Substitute Senate Bill No. 6589 be substituted therefor, and the substitute bill do pass.

Signed by Senators Hargrove, Chair; Costa, Vice Chair; Carlson, Franklin, Hewitt, Kastama, Long and Stevens.

Staff: Fara Daun (786-7459)

Background: There has been concern for some time that there has been no ability for persons with mental health care needs to express their wishes for their care during the times when their illness causes them to be unable to communicate their considered wishes. In some cases, the Involuntary Treatment Act can serve to provide care at these times, but in most cases, the person does not reach the high standard for involuntary treatment and may be unable to access treatment due to his or her inability to express his or her instructions or preferences with regard to mental health care.

Many other states permit the use of an "advance directive" to mental health providers which the person prepares at a time when he or she has the capacity to express his or her instructions and preferences. Though states vary in the specifics, this document provides the person's instructions and preferences in much the same way that "living will" provisions guide treatment providers at a time when the seriously ill person cannot express those wishes.

Summary of Bill: Any person with capacity may create a "mental health advance directive" expressing his or her wishes about his or her mental health treatment. The advance directive must be respected by medical and mental health professionals, guardians, agents, attorneys-in-fact, and other surrogate decision makers acting on behalf of the document's creator.

An advance directive may include one or more of the following provisions: preferences and instructions for mental health treatment; consent, or refusal to consent to specific types of treatment or admission and retention for treatment; descriptions of situations that may cause a mental health crisis; suggestions for alternative responses that supplement or are in lieu of

direct mental health treatment; appointment of an agent to make mental health treatment decisions; consent to release of health care information to other providers or third parties; and the person's nomination of a guardian or limited guardian if a court commences guardianship proceedings. A model form is provided, but an advance directive is not required to be in that form.

A person is presumed to have capacity to create or revoke a directive. A person with capacity is a person who can consent to medical treatment. The person who made the directive (the principal), his or her agent, a health care provider or a professional person may request a determination of the principal's capacity. The determination may be made by a superior court, two health care providers, or one mental health professional and one health care provider. A revocation is valid unless the person is determined to have been incapacitated at the time. The determination must occur within 48 hours of the attempted revocation or it is be presumed that the person did have the capacity to revoke.

A directive must be in writing, dated and signed and witnessed by two people. There are limitations on who may witness a directive or serve as an agent. These limitations are directed to exclude persons with real or potential conflicts of interest. When a directive is received by a treatment provider, it must be made a part of the person's medical record and the professional person is deemed to have actual knowledge of its contents. Revocation must also be in writing, except as otherwise provided. If a person authorizes inpatient treatment, but at the time of admission refuses treatment, the refusal is considered a revocation of that provision unless the person is determined to be incapacitated. An incapacitated principal who attempts to revoke his or her consent to admission may be held for treatment only if the admitting physician also obtains the agent's consent; makes a written determination that the principal needs inpatient evaluation or treatment and it cannot be accomplished in a less restrictive setting; and documents his or her findings and treatment recommendations in the principal's medical record. Voluntary inpatient admission by an agent or pursuant to an advance directive is limited to 72 hours, unless the person later consents to a longer admission.

A treatment provider must follow the directive unless following the directive would violate the law or the accepted standard of care, the requested treatment is not available, would endanger any person's life or health, or would mean that the person would be incapable of participating in any available treatment plan that would give the person a realistic opportunity of improving his or her condition. A treatment provider is not subject to civil liability or professional misconduct sanctions when the provider, in good faith: treats without actual knowledge of an advance directive or its revocation; makes a determination of capacity or incapacity, treats according to an advance directive that is later found to be invalid; does not treat according to the advance directive for a reason permitted by statute; or the provider treats according to the directive.

The provisions for appointing an agent and nominating a guardian in an advance directive are integrated into the existing provisions relating to powers of attorney and guardianship proceedings. Creation of an advance directive does not constitute an indication that a person has a mental disorder and may not be required for receiving mental health or physical health services or as a condition of admission or discharge from a mental health or long-term care facility.

Where a person has a guardian, the guardianship controls the application of a previously executed directive.

Where a person has executed more than one mental health advance directive, the most recent directive is construed to be the person's preferences and instructions unless provided otherwise in the directive. Where there is more than one kind of directive and they are inconsistent, the most recent directive controls as to the inconsistent or conflicting provision.

Appropriation: None.

Fiscal Note: Requested on January 23, 2002.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Testimony For: This bill reflects the work of a workgroup that has been meeting over the interim and this bill answers the questions that were asked last year. It represents a new approach for dealing with the existing problem that for many mentally ill persons. The system has become a revolving door in which mentally ill persons decompensate, families seek treatment but the person cannot be treated because they are not sick enough for involuntary treatment, the person decompensates further and ends up in jail or the emergency room, gets stabilized and the cycle starts again. This has tremendous potential to help people earlier, empower the consumer, improve continuity of care, relieve the confusion about whether advance directives are available in this state, and to save money. There are mental health advance directives in place in at least 14 states. The bill balances the protection for a client. There was support for an amendment that would limit a voluntary admission under an advance consent provision if it would take force to admit the client.

The Mental Health Division supports the concept because it offers consumers an opportunity to improve their care. DSHS has concerns about admitting a person to treatment over his or her contemporaneous objections. Some clients have a fear of the unknown, this may become less as the directives are more widely used.

If the maker puts something dangerous or illegal into the advance directive, the bill provides three reasons not to honor the request: the request is illegal, the request is not within reasonable medical practice, and the requested services are not available.

This is public policy that encourages people to plan ahead and encourages earlier, rather than later, intervention. Earlier intervention is safer, cheaper and less disruptive of client's lives. There is a concern that an advance directive not be able to be used by nursing homes to shift a difficult client out of their system simply because the client is difficult.

A consumer advocate testified that she had prepared an advance directive under the existing law, but that law does not address the problems specific to mental health. The client has strong family advocates but under current law has had concerns whether a provider will honor her directive.

There is a need to address the considerations raised by the interaction of the advance directive and the guardianship statute. The interaction between this and existing provisions on medical directives and durable powers of attorney needs to be clarified.

The counties and the regional support networks support the legislation, and would like clarification regarding revocation and regarding the interaction with the Involuntary Treatment Act.

Testimony Against: There is a need to address the issue related to a person's ability to revoke while the person is incapacitated. The hospitals were not at the table over the interim.

Testified: Senator Karen Keiser (sponsor); Debra Srebnik, University of Washington (pro); Lisa Brodoff, Seattle University School of Law (pro); Karl Brimner, Director, Mental Health Division, DSHS (con); Kary Hyre, Long-Term Care Ombudsman (pro/concerns); Tom Richardson, NAMI of Washington (pro); Andrea Stephenson, Empower Alliance (pro/concerns); Lisa Thatcher, Washington State Hospital Association (concerns); Jean Wessman, Washington State Association of Counties, Regional Support Networks (pro).