HOUSE BILL REPORT
HB 1041

As Reported by House Committee On:
Judiciary
Appropriations

Title: An act relating to mental health advance directives.

Brief Description: Authorizing mental health advance directives.

Sponsors: Representatives Lantz, Kagi, Conway, Chase, Kirby, Dickerson, Kenney, Campbell, Talcott, Skinner and Jarrett.

Brief History:
Committee Activity:
Judiciary: 1/24/03, 2/25/03 [DPS];
Appropriations: 3/6/03, 3/8/03 [DPS(JUDI)].

Brief Summary of Substitute Bill

- Establishes procedures and requirements for a person with capacity to create a mental health advance directive.
- Establishes duties and responsibilities of agents and providers regarding directives.
- Codifies a mental health advance directive form.
- Creates a class C felony for fraudulently creating or revoking another person's directive.

HOUSE COMMITTEE ON JUDICIARY

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 9 members: Representatives Lantz, Chair; Moeller, Vice Chair; Carrell, Ranking Minority Member; McMahan, Assistant Ranking Minority Member; Campbell, Flannigan, Kirby, Lovick and Newhouse.

Staff: Trudes Hutcheson (786-7384).

Background:

Although there are statutes authorizing "living wills" and powers of attorney, Washington does not have laws that explicitly govern advance directives for mental health treatment.

Under the Natural Death Act, a person may prepare an advance directive ("living will") instructing providers about the person's end-of-life decisions. The person must sign the directive in the presence of two witnesses and may revoke the directive at anytime.

The durable power of attorney statutes allow a person to appoint an agent (called an attorney in fact) to make decisions on the principal's behalf. The power of attorney may be as broad or limiting as the principal chooses and may authorize the attorney in fact to make certain health care decisions for the principal. The attorney in fact may not consent to involuntary commitment of the principal, therapy that induces convulsion, surgery solely for the purpose of psychosurgery, or other psychiatric or mental health procedures that restrict freedom of movement.

Under the involuntary treatment laws, a person may be involuntarily committed to inpatient mental health treatment if the person, as a result of a mental disorder, presents a likelihood of serious harm to self or others or is gravely disabled. Generally, the county designated mental health professional (CDMHP) must petition the court to involuntarily commit the person for evaluation and treatment. The courts, CDMHPs, and treatment facilities must follow various procedural requirements and reviews. A person may voluntarily admit himself into an inpatient treatment facility. Generally, a person voluntarily admitted must be released immediately upon that person's request.

Approximately 16 states have enacted legislation recognizing mental health advance directives. Although the states vary in the specifics, the laws generally authorize a person to create a mental health advance directive in which the person can consent to treatment, refuse treatment, consent to inpatient treatment, and appoint an agent to make treatment decisions on the person's behalf.

Summary of Substitute Bill:

The Legislature makes certain findings regarding the ability of mentally ill individuals to make their own treatment decisions and their need for some method of expressing those decisions while they have capacity.

(1) Creation of a Mental Health Advance Directive

An adult with capacity may create a mental health advance directive. A directive may include such provisions as the person's consent to specific types of mental health treatment, refusal to consent to treatment, consent to treatment in an inpatient facility for up to 14 days, instructions regarding the principal's personal affairs, and the appointment of an agent.

With certain exceptions, the durable power of attorney statutes generally apply to agents appointed under a directive. The principal must notify the agent in writing of the appointment. The principal may revoke the appointment of an agent as provided under current law or under conditions stated by the principal in the appointment.

When creating the directive, the principal must designate whether the principal chooses to be able to revoke the directive only when he or she has capacity or whether the principal chooses to be able to revoke the directive at any time, even during periods of incapacity. The directive must be in writing, signed, and witnessed by two adults. The bill lists who may not act as witnesses.

(2) Determination of Capacity

An adult is presumed to have capacity unless he or she has been found to be incapacitated under the procedures established in the bill or unless a court has found the person incapacitated to give informed consent to treatment under the guardianship laws.

"Incapacitated" is defined as: (a) a person who is unable to understand the nature, character, and anticipated results of proposed treatments or alternatives; the recognized serious possible risks, complications and anticipated benefits of treatments and alternatives, including nontreatment; or is unable to communicate his or her understanding or treatment decisions; or (b) a person who is incompetent under the guardianship laws.

A principal, agent, professional person, or health care provider may request a capacity determination. The determination may be made by either a superior court, two health care providers, or one mental health professional and one health care provider. One of the persons making the capacity determination must be a psychiatrist, psychologist, or psychiatric advanced registered nurse practitioner. If the court is making the determination, certain procedural requirements apply.

The bill establishes various procedures for capacity determinations, including the time periods under which a determination must be made. If no determination is made within the required time, the principal is presumed to have capacity.

An initial determination of capacity must be completed within 48 hours of the request for a determination. If an incapacitated principal is admitted to inpatient treatment pursuant to a directive, the principal's capacity must be reevaluated within 72 hours of admission or when there has been a change in the principal's condition indicating the principal has regained capacity, whichever is sooner.

If the principal requests a redetermination of capacity while being treated in an inpatient facility, the redetermination must be made within 72 hours of the request. If an incapacitated principal is being treated on an outpatient basis and requests a

redetermination of capacity, the redetermination must be made within five days of the request. The bill also establishes who is responsible for obtaining the determination of capacity under various circumstances.

(3) Revocation of a Mental Health Advance Directive

A person with capacity may revoke all or part of the directive. An incapacitated person may revoke the directive only if he or she chose to be able to revoke during periods of incapacity. Revocation must be by written statement by the principal or at the principal's direction, but need not follow any specific form. The principal must provide a copy of the revocation to the agent and health care provider, professional person, or health care facility that received a copy of the directive from the principal.

(4) Consent to Admission to Inpatient Treatment

A principal may consent in the directive to be treated in an inpatient facility for up to 14 days. However, the directive may not be used as the authority for inpatient admission for more than 14 days in any 21-day period.

If a principal consented to inpatient treatment, but while incapacitated refuses to be admitted and chose not to be able to revoke while incapacitated, then the principal may only be admitted if certain procedures are followed. In those circumstances, a physician member of the treating facility's staff must (a) evaluate the principal's mental condition and determine, along with another health care provider or mental health professional, that the principal is incapacitated; (b) obtain informed consent of the agent; (c) determine that the principal needs inpatient evaluation or treatment that cannot be accomplished in a less restrictive setting; and (d) document the findings and recommendations in the medical record.

The principal who consented to inpatient treatment but who takes action demonstrating a desire to be discharged and makes statements requesting discharge, shall be discharged. No principal shall be restrained in any way to prevent discharge. In addition, a principal may immediately seek injunctive relief for release from the facility. Consent to inpatient treatment in a directive is effective only while the treatment provider is in substantial compliance with the material provisions of the directive related to inpatient treatment.

(5) Provider Responsibilities

A treatment provider must make the directive part of the principal's medical record and is deemed to have actual knowledge of the contents. When receiving the directive, the treatment provider must promptly notify the principal if the provider is unable or unwilling to comply with the directive for any reason.

When acting under a directive, the treatment provider must act in accordance with the

directive to the fullest extent possible, unless (a) compliance would violate the accepted standard of care; (b) the requested treatment is not available; (c) compliance would violate applicable law; or (d) it is an emergency situation and compliance would endanger any person's life or health.

A provider is not subject to civil liability or professional conduct sanctions for providing treatment according to a directive, for making capacity determinations, and for other acts related to the directive if the provider acts in good faith and without negligence.

A directive does not create an entitlement to treatment, supercede a determination of medical necessity, or obligate a treatment provider to pay for costs associated with treatment.

In the case of a principal who is committed under existing involuntary commitment laws (such as the Involuntary Treatment Act, the laws related to the special commitment center, or the criminal insanity laws), the provisions of the person's MHAD that are inconsistent with the purpose of the commitment or with any court order relating to the commitment are invalid during the commitment. Remaining provisions of the person's directive are advisory while the person is committed, but the treatment provider should follow the directive whenever possible unless some other exception applies.

(6) Other Provisions

The bill contains other provisions relating to treatment, providers, and agents. The bill also:

- prohibits any person from using abuse, neglect, financial exploitation, or abandonment to carry out the directive;
- codifies a form and a notice to the principal about the effects of a directive;
- creates a class C felony for fraudulently creating or revoking another person's directive; and
- requires the Joint Legislative Audit and Review Committee (JLARC) to evaluate the impact of the bill on long-term care facilities.

Substitute Bill Compared to Original Bill:

The substitute makes the following changes:

- Limits how often a principal may be admitted into inpatient treatment under an MHAD (not more than 14 days in any 21-day period).
- Explicitly states that a principal who consented to inpatient treatment but who takes action demonstrating a desire to be discharged and makes statements requesting discharge, shall be discharged. The principal may not be restrained in any way to prevent discharge.
- Specifies that in cases where a principal is involuntarily committed under existing

involuntary commitment or treatment laws, the provisions in the principal's MHAD that are inconsistent with the purpose of the commitment are invalid during the commitment.

- Requires the JLARC to evaluate the impact of the bill on long-term care facilities.
- Clarifies definitions and makes various other technical changes.

Appropriation: None.

Fiscal Note: Requested on January 15, 2003.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of session in which bill is passed.

Testimony For: There are people trying to use mental health advance directives currently, but providers and consumers have concerns about the legal status of these directives. This bill will help clarify the general legal validity of mental health directives. The bill takes into account the wide range of perspectives. The bill is conservative regarding when providers are required to follow a MHAD. MHADs are valuable and can help a person avoid the trauma and costs of hospitalizations. Many people want to plan for their care and they know what works for them. This bills focuses on giving the consumer choices. MHADs allow a consumer to plan for their own recovery and get proactive treatment. The bill gives dignity and respect to the consumers. Early intervention of mental illness is the key. Consumers often feel like everyone else has control over the consumer's life. The bill gives control to the consumer.

Testimony Against: The idea that people with mental illnesses decompensate and get worse is not true. It is possible to recover without medications. The bill is not about providing consumers with choice because the provider's standard of care will be the standard that determines what is provided. The definition of incapacitated is very broad. The bill is designed to bypass the process currently in place for involuntary commitments. Courts have recognized that being committed to a psychiatric hospital is a significant deprivation of a liberty and a person has due process rights. Although injunctive relief is provided in the bill, consumers won't know how to seek injunctive relief. The consumer has no right to counsel and no true judicial review. It is unconstitutional to involuntarily commit a person who is not dangerous. These admission should be treated like voluntary admissions.

Testified: (In support) Debra Srebnik, University of Washington; Lisa Brodoff, Seattle University School of Law; Harrison Fisher and Pat Lovett, NAMI Washington; and Sharon Case, Association of Advanced Practice Psychiatric Nurses.

(Opposed) Richard Warner, Citizens Commission on Human Rights; Carole Willey,

Holistic Health and Advocacy; and Richard Lichtenstadter, Washington Defender Association and Washington Association of Criminal Defense Lawyers.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill by Committee on Judiciary be substituted therefor and the substitute bill do pass. Signed by 26 members: Representatives Sommers, Chair; Fromhold, Vice Chair; Sehlin, Ranking Minority Member; Pearson, Assistant Ranking Minority Member; Alexander, Buck, Clements, Cody, Conway, Cox, DeBolt, Dunshee, Grant, Hunter, Kagi, Kenney, Kessler, Linville, McDonald, McIntire, Miloscia, Pflug, Ruderman, Schual-Berke, Sump and Talcott.

Minority Report: Without recommendation. Signed by 1 member: Representative Boldt.

Staff: Amy Hanson (786-7118).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Judiciary:

No new changes were recommended.

Appropriation: None.

Fiscal Note: Not Requested.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of session in which bill is passed.

Testimony For: This bill will save money as it helps people take care of their mental illness earlier. In the end, the bill will save resources of the state, counties, and local governments.

Testimony Against: Sections 11 and 13 would require increased court hearings as a result of capacity determinations. There are potential liability issues of informed consent and due process associated with the bill.

Testified: (In support) Brad Boswell, National Association of the Mentally Ill; and Representative Lantz, prime sponsor.

(Opposed) Richard Warner, Citizens' Commission on Human Rights.