SENATE BILL REPORT
SB 5223

As Reported By Senate Committee On:
Children & Family Services & Corrections, February 18, 2003

Title: An act relating to mental health advance directives.

Brief Description: Authorizing mental health advance directives.

Sponsors: Senators Keiser, Parlette, Hargrove, Deccio and Kline.

Brief History:
Committee Activity: Children & Family Services & Corrections: 1/24/03, 2/18/03 [DPS].

SENATE COMMITTEE ON CHILDREN & FAMILY SERVICES & CORRECTIONS

Majority Report: That Substitute Senate Bill No. 5223 be substituted therefor, and the substitute bill do pass.

Signed by Senators Stevens, Chair; Parlette, Vice Chair; Carlson, Deccio, Hargrove, McAuliffe and Regala.

Staff: Fara Daun (786-7459)

Background: There has been concern for some time that persons with mental health care needs have no means to express their wishes for their care during the times when their illness makes them unable to communicate their considered wishes or make medical decisions. In some cases, the Involuntary Treatment Act can serve to provide care at these times. In most cases, however, 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 give informed consent. Many other states permit the use of a mental health "advance directive" that 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 Substitute Bill: Any person with capacity may create a "mental health advance directive" expressing his or her preferences and instructions about mental health treatment. The 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.

A directive must be in writing, dated, signed and witnessed by two people and must substantially follow the statutory form. There are limitations on who may witness a directive or serve as an agent that are directed to exclude persons with real or potential conflicts of interest. A 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 inpatient 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; and
- the person's nomination of a guardian or limited guardian if a court commences guardianship proceedings.

A person is presumed to have capacity to create or revoke a directive. A person with capacity is a person who can give informed 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 two health care providers, or one mental health professional and one health care provider, or if the principal or his or her agent request a court determination, a superior court. Where the determination is made by the designated treatment providers, one of the providers must be a psychiatrist, psychologist, or advanced registered psychiatric nurse.

A principal may revoke a directive in writing at any time he or she has capacity. When executing an advance directive, the principal must choose whether or not to be able to revoke the directive at times when he or she is incapacitated. If a principal chooses to limit himself or herself to revocation only when he or she has capacity, his or her revocation is valid unless he or she is determined to be incapacitated at the time. An initial determination of capacity must occur within 48 hours of the request. When an incapacitated person requests a redetermination, the redetermination must occur within 72 hours if the person is in inpatient treatment or within five days if the person is in outpatient treatment. If the determination is not made within the time limits, the principal is presumed to have capacity.

A principal may consent to inpatient admission for a maximum of 14 days. If a principal who has consented to inpatient treatment in his or her advance directive objects to treatment at the time of admission, the refusal is addressed in one of three manners:

- The principal's choice at the time supersedes the directive and provisions of the directive are deemed waived unless the principal is determined to be incapacitated.
- If the principal is incapacitated and chose to be able to revoke the directive during periods of incapacity, the consent to admission is revoked and the principal will not be admitted unless he or she meets the criteria for involuntary treatment.
- If the principal is incapacitated and chose not to be able to revoke the directive during periods of incapacity, the principal's instruction in his or her directive are followed over his or her attempted revocation and he or she may be admitted 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. Because this is a voluntary admission, however, a principal who takes action to leave beyond a stated objection must be discharged or not admitted unless he or she meets the criteria to be detained under the existing Involuntary Treatment Act.

A treatment provider acting under a directive must follow the directive unless to do so would violate the law or the accepted standard of care, the requested treatment is not available, or

would endanger any person's life or health. There are further exceptions for civilly committed and incarcerated persons. Provisions in the directives of civilly committed persons that conflict with the purpose of the commitment or court orders related to the commitment are invalid during the commitment. Remaining provisions are advisory but should be followed if possible. Provisions in the directive of an incarcerated person that are contrary to reasonable penological objectives or to the outcome of an administrative hearing regarding involuntary medications are invalid during periods of incarceration. If a treatment provider acting under a directive is unable to follow the directive, the provider must note the deviation and the reason in the principal's medical record. At the time of receiving a directive, if a provider is unable or unwilling to follow the directive, he or she must notify the principal or his or her agent and note the reason in the principal's medical record.

A provider is not subject to civil liability or professional misconduct sanctions when the provider, in good faith and without negligence:

- 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
- treats according to the directive.

A person may not be compelled to execute or refrain from executing a directive as a criterion for insurance coverage, receiving mental health treatment, admission or discharge from a facility. No person or health care facility may use or threaten abuse, neglect, financial exploitation, or abandonment to carry out a directive. The principal may contest the validity of his or her directive. Fraudulent creation or revocation of a mental health advance directive is a class C felony ranked as a level I offense.

Where a person has a guardian, the guardianship controls the application of a previously executed directive. Some existing limitations on agents to consent to treatment for a principal are removed when the principal has consented to the treatment in his or her 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.

Substitute Bill Compared to Original Bill: The substitute makes clarifying and technical amendments. It also:

- Corrects the definition of "health care facility";
- Makes provisions in a civilly committed principal's directive that conflict with the purpose of the commitment or court orders related to the commitment invalid during the commitment. Remaining provisions are advisory during the commitment.
- Provides that the directive of an incarcerated principal does not have to be followed if, without the specific treatment, there is a substantial possibility that the principal will harm self or others before his or her condition improves;
- JLARC reports to the Legislature on the impacts of the legislation on Medicaid persons in long-term care facilities; and

- Simply possessing another person's directive that is known to be invalid does not subject a person to criminal sanctions.

Appropriation: None.

Fiscal Note: Requested on January 21, 2003.

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

Testimony For: This legislation is balanced and thoughtful. It was negotiated and drafted through a two-year process with the participation of an extensive stakeholder group. Under current law, mentally ill persons cannot get needed care at the time they need it because they cannot consent to treatment at that time. When a person decompensates to the point of needing civil commitment, he or she never comes all the way back to the functionality he or she had before the decompensation. This legislation would help people get treatment earlier. A current study with over 100 participants has shown that a significant percentage do not want to be able to revoke the directive during periods of incapacity, but at least as many consumers do want to be able to revoke. The legislation permits the consumer to choose whether or not to be able to revoke. In the 37 crisis events so far in the study, 11 directives specified alternatives to hospitalization which saved a significant amount of money. Only three of the 37 events resulted in an attempt to revoke and two of the three the revocation affected only a specific section. The legislation will provide strong support for the use of mental health advance directives for all stakeholders. It will empower consumers and help them in the recovery process. Strong support of the protections for the consumer, especially the language prohibiting a person to use or threaten abuse or neglect to enforce a directive and the creation of a crime for fraudulent creation or revocation of a directive.

Testimony Against: It needs to be clear that this does not create a different kind of commitment and that there is not authority to hold a person against his or her will outside of the current Involuntary Treatment Act. It needs to be clear that this does not create a new and lower standard for civil commitment. The current mental health system does not help consumers. One year studies show no recoveries. This legislation supports continuing with the current system and the use of psychotropic medications when what is needed is a reform of the system itself. There were concerns expressed that some consumers have not had their rights respected in the current system and there are fears that the legislation will not address that problem.

Testified: Senator Karen Keiser (sponsor); Debra Srebnik, University of Washington (pro); Jean Wessman, Washington Association of Counties & the Regional Support Networks (pro with concerns); Sherry Appleton, Washington Defender Association (concerns); David Lord, Washington Protection & Advocacy (concerns); Harrison John Fisher, NAMI of Washington (pro); Richard Warner, Citizens' Commission on Human Rights (con); Carole Willey, Holistic Health & Advocacy (con); Lynn Dearing, Association of Advanced Practice Psychiatric Nurses in Washington.