

Chapter 4B:

Mental Health Advance

Directives

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For reference purposes, this chapter was prepared from laws, cases, and materials selected by the authors, which were available as of February 14, 2006.

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Chapter Outline

| | | |
|-------------|--|--------------|
| 4B.1 | Introduction..... | 4B-2 |
| 4B.2 | Contents and Scope of the Directive..... | 4B-2 |
| 4B.2.1 | Mental Health Advance Directive Definitions | |
| 4B.2.2 | Scope of Directive | |
| 4B.2.3 | Statutory Form | |
| 4B.2.3.1 | Statement of Intent | |
| 4B.2.3.2 | When the Directive is Effective | |
| 4B.2.3.3 | Duration of the Directive | |
| 4B.2.3.4 | Terms of Revocation | |
| 4B.2.3.5 | Treatment Preferences and Instructions | |
| 4B.2.3.6 | Appointment of an Agent | |
| 4B.2.3.7 | Other Documents | |
| 4B.2.3.8 | Notification of Others and Care of Personal Affairs | |
| 4B.2.3.9 | Signature | |
| 4B.2.4 | Prohibited Provisions | |
| 4B.2.5 | Witnessing Requirements | |
| 4B.2.5.1 | Declaration of Witnesses | |
| 4B.2.6 | Appointment of an Agent | |
| 4B.2.6.1 | Rights and Duties of an Agent | |
| 4B.2.6.2 | Rights of a Principal in Relation to an Agent | |
| 4B.2.7 | Revocation of the Directive | |
| 4B.2.7.1 | When a Directive May be Revoked | |
| 4B.2.7.2 | Procedures for Revocation | |
| 4B.2.7.3 | When a Revocation is Effective | |
| 4B.2.7.4 | Revocation by Court Order | |
| 4B.2.7.5 | Waiver | |
| 4B.3 | Provider Responsibilities and Immunities | 4B-8 |
| 4B.3.1 | Who Must Comply with the Statute | |
| 4B.3.2 | Receipt of a Directive by a Provider | |
| 4B.3.2.1 | Ability to Object on Initial Receipt of Directive | |
| 4B.3.2.2 | Ability to Object Once Acting Under Authority of a Directive | |
| 4B.3.3 | No Entitlement to Treatment | |
| 4B.3.4 | Obligation to Inquire About Directives | |
| 4B.3.5 | Immunities | |
| 4B.4 | Inpatient Admission Pursuant to a Directive | 4B-10 |
| 4B.4.1 | Process Requirements | |
| 4B.4.2 | When Principal Refuses to be Admitted | |
| 4B.4.3 | Long Term Care Facilities | |
| 4B.4.4 | Guardians' Ability to Admit Patients | |
| 4B.5 | Capacity Determinations Process | 4B-11 |
| 4B.5.1 | Who May Request a Determination | |
| 4B.5.1.1 | Requests by a Professional Person or a Health Care Provider | |
| 4B.5.2 | Who May Make a Determination | |
| 4B.5.3 | Determination by a Court | |
| 4B.5.4 | Capacity Determination Time Frames and Obligations | |
| 4B.5.4.1 | Inpatient Treatment | |
| 4B.5.4.2 | Outpatient Treatment | |
| 4B.5.4.3 | Failure to Meet Time Frames for Capacity Determination | |
| 4B.5.5 | Duty of Agent | |
| 4B.5.6 | Payment of Capacity Determinations | |
| 4B.6 | Directives and the Involuntary Civil Commitment Process | 4B-14 |
| 4B.7 | Resources for Assistance | 4B-15 |

Volume 1: Patient Care Information, Treatment and Rights

4B.1 Introduction¹

In 2003, the Washington State Legislature passed Washington’s first law governing advance directives for mental health treatment.² Codified at Chapter 71.32 RCW, the statute provides persons with cyclical mental illness a legal mechanism to express preferences for mental health treatment during periods of incapacity.

Stakeholder groups representing a variety of interests expressed a myriad of concerns during the bill development process. While most of these concerns were eventually resolved, some were not. Those unresolved concerns have the potential to create difficult situations for providers.

4B.2 Contents and Scope of the Directive

4B.2.1 Mental Health Advance Directive Definitions

As governed by Chapter 71.32 RCW, a mental health advance directive (hereinafter “directive”) is a document in which an individual may (a) outline instructions/preferences regarding his or her mental health treatment, (b) designate a surrogate decision maker to make mental health treatment decisions on his or her behalf, or (c) do both. Although some of the definitions used in Chapter 71.32 RCW are similar in usage to those in other Washington state statutes such as the Natural Death Act (Chapter 70.122 RCW) and the Power of Attorney Chapter (Chapter 11.94 RCW), there are enough key distinct definitions to warrant a review of the definition section of the directive statute. Please consult RCW 71.32.020 for the complete list of statutory definitions specific to Chapter 71.32 RCW.

Directives Are Not Just for People With “Mental Illness”

Most people think of mental illnesses such as schizophrenia or depression as mental disorders covered by directives, but the term includes *any* organic, mental, or emotional impairment that adversely affects an individual’s cognitive or volitional functions.

Individuals with any condition, or family history of a condition, which could affect their cognitive abilities, such as Alzheimer’s or any form of dementia, should consider executing a directive. Having a directive in place may help the individual and his or her family avoid the civil commitment process in the event psychiatric hospitalization or medication is needed.³

¹ The author would like to thank Taya Briley and Kristin Miles for their contribution to this chapter through their presentation, entitled “Washington’s New Mental Health Advance Directive Law,” at the Spring 2003 Washington State Society of Healthcare Attorneys Conference.

² At the time legislation was being considered by the Washington State Legislature, about 14 other states had adopted statutes concerning mental health advance directives, psychiatric advance directives, psychiatric wills, or similar documents. The statutes of other states differ widely in approach, ranging from allowing a person to choose from a narrow range of treatments specified by statute, to broader documents that allow a person to refuse treatment and provide instructions on care in a narrative format. Relative to the laws of other states, Washington’s statute is one of the broadest approaches yet, and requires careful implementation by affected entities.

³ The line between what is considered “mental health” treatment versus what is considered “medical” treatment is not always clear. A conservative approach to defining these terms may result in restrictions on the decision-making authority of surrogate decision-makers that were likely never intended. See RCW 11.92.043(5) and RCW 11.94.010(3)(b). For example, an individual suffering cardiac arrest may become confused, combative, or agitated due to decreased oxygen to the brain. This impact on cognitive and volitional functions could arguably be a “mental disorder” requiring “mental health” treatment. Yet it is routinely treated with the consent of a surrogate decision-maker, and may include antipsychotic or other psychiatric medications as needed.

4B.2.2 Scope of Directive

An adult with capacity may execute a directive as the “principal”.⁴ The document may include any provision relating to the principal’s mental health treatment, the care of the principal and instructions regarding the principal’s personal affairs.⁵ The directive may contain:

- Preferences and instructions for mental health treatment;
- Consent to specific types of mental health treatment;
- Refusal of consent to specific types of mental health treatment;
- Consent to admission to a facility for mental health treatment for up to fourteen (14) days;
- Descriptions of situations that might trigger a mental health crisis;
- Suggested alternatives to mental health treatment;
- Appointment of an agent to make mental health treatment decisions (including voluntary admission to inpatient mental health treatment); and
- Nomination of a guardian or limited guardian for consideration by a court.⁶

4B.2.3 Statutory Form

RCW 71.32.260 contains a model directive that includes a preamble outlining important facts for the principal to consider when filling out the form. The directive must be in writing⁷ and in substantially the same form as the model directive.⁸ The sections of the model directive are as follows:

4B.2.3.1 Statement of Intent

As required by RCW 71.32.060(1)(b), the directive must contain language clearly indicating the principal’s intent to create a directive.

4B.2.3.2 When the Directive is Effective

The principal may designate in the directive when it is to become effective.⁹ The model directive provides the following three options:

- Immediately upon signing the directive;
- When the principal becomes incapacitated; or
- When certain circumstances, symptoms or behaviors occur as specified by the principal.

Although all or part of a directive may become effective at a later time as specified by the principal, the directive is valid upon execution.¹⁰

to alleviate the agitation and confusion. In the coming years, with the aging of the “baby boomers”, Washington may need to clarify the application of mental health law to these conditions, including Alzheimer’s and dementia, or risk a generation of elders whose treatment and medications will be decided by the courts instead of their families and physicians.

⁴ See RCW 71.32.020(13).

⁵ See RCW 71.32.050(3).

⁶ See RCW 71.32.050.

⁷ See RCW 71.32.060(1)(a).

⁸ See RCW 71.32.260. It should be noted that although RCW 71.32.060 lists the elements that need to be present in a directive in order for it to be valid, there is language in the model directive that appears to add additional requirements for the document’s validity. For example, the model form requires the principal to indicate when the directive is intended to be effective and when the directive expires. These elements are not included in RCW 71.32.060.

⁹ See RCW 71.32.060(3).

¹⁰ Id.

Volume 1: Patient Care Information, Treatment and Rights

4B.2.3.3 Duration of the Directive

The directive may be effective either for an indefinite period of time or automatically expire after a number of years as specified by the principal, based upon which choice is made by the principal at the time the document is executed.

4B.2.3.4 Terms of Revocation

The principal chooses between the ability to revoke only when he or she has capacity, or the ability to revoke even if he or she is incapacitated.

4B.2.3.5 Treatment Preferences and Instructions

The following are options under the "treatment preferences" section of the model form:

- Provide preferences for physicians and other providers;
- Identify physicians by whom the principal does not want to be treated;
- Consent to/refuse psychiatric medications and specify other medication preferences;
- Rank preferences for treatment in the event of a need for twenty-four (24) hour psychiatric care;
- Consent to/refuse (or authorize an agent to consent to/refuse) inpatient treatment or consent under certain circumstances;
- Specify preferences for treatment at certain hospitals or refuse to consent to admission to certain hospitals;
- Specify interventions to be tried prior to seclusion or restraint;
- Indicate preferences regarding seclusion, restraint and emergency medications;
- Consent to/refuse (or authorize an agent to consent to/refuse) electroconvulsive therapy, or consent under certain conditions; or
- Specify who may not visit during treatment and provide general instructions about how the principal can be best helped by treatment staff.

Directives Can Contain Advance Consent

A directive can contain an individual's signature that satisfies informed consent requirements for psychiatric hospitalization or medication.¹¹

The fact that a patient has executed a directive does not mean the person is not capable of providing informed consent.¹²

4B.2.3.6 Appointment of an Agent

The principal may, but is not required to:

- Designate an agent and an alternate agent and specify limits on the agent's authority.
- Limit his or her ability to revoke the agency appointment.
- Nominate a person to act as a court appointed guardian.

4B.2.3.7 Other Documents

The model directive provides an opportunity for the principal to identify whether he or she has also executed a health care power of attorney, a living will, or has appointed more than one agent, in which case the most recently appointed agent controls unless the principal specifies otherwise.¹³

¹¹ RCW 71.32.260.

¹² See RCW 71.32.210.

¹³ See RCW 71.32.180.

4B.2.3.8 Notification of Others and Care of Personal Affairs

The model directive contains a section in which the principal may give direction to his or her agent regarding notification of designated individuals once the directive becomes effective and preferences/instructions regarding personal affairs such as care of dependents/pets/household.

Preferences and instructions included in this section of the form are not the responsibility of a treatment provider and a treatment provider is not required to act on them.¹⁴

4B.2.3.9 Signature

In order for the directive to be valid, the directive must be dated and signed by the principal and witnessed by at least two adults.¹⁵ If the principal is unable to sign, it must be signed at the principal's direction in the presence of the principal.¹⁶

4B.2.4 Prohibited Provisions

A directive may not:

- Create an entitlement to mental health or medical treatment or supersede a determination of medical necessity;
- Obligate any health care provider, professional person, or health care facility to pay the costs associated with the treatment requested;
- Obligate any health care provider, professional person, or health care facility to be responsible for the nontreatment personal care of the principal or the principal's personal affairs outside the scope of services the facility normally provides;
- Replace or supersede the provisions of any will or testamentary document or supersede the provisions of intestate succession;
- Be revoked by an incapacitated principal unless that principal selected the option to permit revocation while incapacitated at the time his or her directive was executed;
- Be used as the authority for inpatient admission for more than fourteen (14) days in any twenty-one (21) day period;¹⁷ or
- Obligate any healthcare provider, professional or healthcare facility to provide care that would violate accepted standard of care.¹⁸

4B.2.5 Witnessing Requirements

The following individuals may not witness a directive:

- A person designated to make health care decisions on the principal's behalf;
- A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed;
- 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;
- A person who is related by blood, marriage, or adoption to the person or with whom the principal has a dating or other household or family-type relationship;¹⁹
- A person who is declared to be an incapacitated person; or

¹⁴ See RCW 71.32.070(3).

¹⁵ See RCW 71.32.060(1)(c) and (e).

¹⁶ See RCW 71.32.060(1)(c).

¹⁷ See RCW 71.32.070.

¹⁸ RCW 71.32.150(2).

¹⁹ See RCW 26.50.010 for a complete list of relationships that exclude a person from serving as a witness.

Volume 1: Patient Care Information, Treatment and Rights

- A person who would benefit financially if the principal making the directive undergoes mental health treatment.²⁰

4B.2.5.1 Declaration of Witnesses

Each witness must declare in the directive that:

- He or she personally knows the principal,
- He or she was present when the principal dated and signed the directive, and
- The principal did not appear to be incapacitated or acting under fraud, undue influence or duress.²¹

4B.2.6 Appointment of an Agent

A directive need not contain a designation of an agent for decision-making purposes. However, if a directive authorizes the appointment of an agent, the provisions of the Power of Attorney Chapter (Chapter 11.94 RCW) and the Informed Consent Statute (RCW 7.70.065) apply unless specifically superceded by a provision in Chapter 71.32 RCW.²² The directive must also indicate that it is the principal's intent that the authority given to the agent shall be exercised regardless of the principal's incapacity.²³

If the principal designates an agent in the directive, he or she must notify the agent in writing of the appointment.²⁴

4B.2.6.1 Rights and Duties of an Agent

For purposes of the directive, an agent has the following rights and duties:

- Agents must act in good faith.
- An agent's decisions must be consistent with instructions and preferences the principal has expressed in the directive (unless the principal has revoked the directive), or if not expressed, otherwise known to the agent.
- If the principal's instructions or preferences are not known, the agent shall make decisions in the best interest of the principal.
- Except as limited by state and federal law regarding health care information, the agent has the same right as the principal to receive, review and authorize use and disclosure of the principal's health care information when acting on the principal's behalf and as required to carry out the agent's duties.
- Unless the agent agrees otherwise, the agent is not personally liable for the cost of treatment.
- The agent may resign or withdraw at any time by giving written notice to the principal and providing notice to certain other persons.²⁵

4B.2.6.2 Rights of a Principal in Relation to an Agent

- If the agency appointment is effective while the principal has capacity, the decisions of the principal supersede the decisions of the agent while the principal has capacity.²⁶
- The principal may revoke an agency appointment according to state law, unless the durable power of attorney²⁷ provides otherwise.²⁸

²⁰ See RCW 71.32.090.

²¹ See RCW 71.32.060(1)(e).

²² See RCW 71.32.100(1).

²³ See RCW 71.32.060(2).

²⁴ See RCW 71.32.100(2).

²⁵ See RCW 71.32.100.

²⁶ See RCW 71.32.100(8).

²⁷ Note: RCW 71.32.100(9) uses the term "durable power of attorney". Presumably, one can assume that the statute is referring to the agency appointment in the directive.

4B.2.7 Revocation of the Directive

Whether a principal may revoke his or her directive during periods of incapacity depends on the choice he or she made at the time the directive was executed.²⁹ The principal may choose to be able to revoke during periods of incapacity and may also choose to not be able to revoke during periods of incapacity.³⁰ A principal may also specify under which circumstances he or she wishes to be able to revoke the appointment of an agent.³¹

4B.2.7.1 When a Directive May be Revoked

A principal with capacity may revoke a directive in whole or in part by written statement.³² An incapacitated principal may revoke only if he or she elected to be able to revoke when incapacitated at the time of executing the directive.³³

A directive that would otherwise have expired, but is effective because the principal is incapacitated, remains effective until the principal is no longer incapacitated, unless the principal has elected to be able to revoke while incapacitated and has revoked the directive.³⁴

4B.2.7.2 Procedures for Revocation

A revocation must be in writing, although it need not take any specific form.³⁵ A directive may be revoked in whole or in part by the express terms of, or to the extent of any inconsistency with, a subsequent directive.³⁶

4B.2.7.3 When a Revocation is Effective

In order to revoke his or her directive, a principal must provide a copy of the revocation to the principal's agent and to each health care provider, professional person, or health care facility that received a copy of the directive from the principal.³⁷ The statement of revocation is effective as to a health care provider, professional person, or health care facility upon receipt and must be made a part of the medical record.³⁸

As to the principal's agent, revocation is also effective upon receipt by the agent.³⁹ The agent must notify the principal's health care providers, professional persons, and health care facilities of the revocation and provide each with a copy.⁴⁰

²⁸ See RCW 71.32.100(9).

²⁹ See RCW 71.32.080.

³⁰ See RCW 71.32.060(1)(d).

³¹ See RCW 71.32.100(9).

³² See RCW 71.32.080(1)(a).

³³ See RCW 71.32.080(1)(b).

³⁴ RCW 71.32.080(6).

³⁵ See RCW 71.32.080(2).

³⁶ See RCW 71.32.080(5)(a).

³⁷ See RCW 71.32.080(3).

³⁸ See RCW 71.32.080(4)(a).

³⁹ See RCW 71.32.080(4)(b).

⁴⁰ Id.

Volume 1: Patient Care Information, Treatment and Rights

4B.2.7.4 Revocation by Court Order

A directive may be superseded or revoked by a court order, including an order entered in a criminal matter.⁴¹

4B.2.7.5 Waiver

When a principal with capacity consents to treatment that differs from, or refuses treatment consented to in, the provisions of his or her directive, the consent or refusal constitutes a waiver of that provision and does not constitute a revocation of the provision or directive unless the principal also revokes the directive or provision.⁴²

4B.3 Provider Responsibilities and Immunities

4B.3.1 Who Must Comply with the Statute

Health care providers, professional persons and health care facilities are required to comply with a valid directive.⁴³ Clinicians who provide services to residents of health care facilities are also required to comply with Chapter 71.32 RCW regardless of a principal's residence.⁴⁴ Please consult with RCW 71.32.020 for the statutory definitions of the providers and entities required to follow this chapter.

4B.3.2 Receipt of a Directive by a Provider

Upon receipt of a directive, a health care provider, professional person or health care facility must make the directive a part of the principal's medical record and is deemed to have actual knowledge of its contents.⁴⁵ Although not required by the statute, providers should have policies and procedures in place to review directives when they are first presented.

4B.3.2.1 Ability to Object on Initial Receipt of Directive

If a health care provider, professional person or health care facility is unable or unwilling to comply with any part or parts of the directive for any reason, an objection can be made. The principal, and if applicable his or her agent, must be notified of the objection and the reason must be documented in the principal's medical chart.⁴⁶ Although the provider will not be required to comply with those provisions if the principal and any agent is promptly notified, the provider must follow all other provisions of the directive.⁴⁷

4B.3.2.2 Ability to Object Once Acting Under Authority of a Directive

Once a provider begins to provide care pursuant to a directive or the instructions of an agent appointed by a directive, the provider must comply with the directive to the fullest extent possible except in the following situations:

- Compliance with the provision of the directive would violate the accepted standard of care established in RCW 7.70.040;
- The requested treatment is not available;
- Compliance would violate the law; or
- The situation constitutes an emergency and compliance would endanger any person's life or health.⁴⁸

⁴¹ See RCW 71.32.080(5)(b).

⁴² RCW 71.32.080(7).

⁴³ See RCW 71.32.020 for definitions of categories of providers and facilities.

⁴⁴ See RCW 71.32.150.

⁴⁵ See RCW 71.32.150(1).

⁴⁶ See RCW 71.32.150(5)(a).

⁴⁷ See RCW 71.32.150.

⁴⁸ See RCW 71.32.150(2).

If a provider is unable to comply with any part or parts of the directive for the reasons listed above, the principal, and if applicable his or her agent, must be notified and the reason documented in the medical record.⁴⁹ All other parts of the directive shall be followed.⁵⁰

4B.3.3 No Entitlement to Treatment

A directive does not create an entitlement to treatment⁵¹ nor are providers obligated to assume the costs of the treatment requested.⁵² Although a principal may specify physician preferences in his or her directive, as with patients in any care setting, this does not mean that a principal may choose any physician he or she wants or demand placement on a specific hospital ward. While treatment relationships are important and every effort should be made to respect patient preferences, a request for a specific physician may be denied if the physician's patient load, specialty, ward assignment, or other factors make him or her unavailable to the requesting patient.

Similarly, a principal may indicate in his or her directive a preference for a medication that is not covered by the principal's healthcare carrier. Providers should therefore follow their standard process whenever a principal requests care that is not covered by his or her insurance, or when a principal is uninsured.⁵³ If a principal requests medication or treatment that the provider does not think is medically appropriate, if the principal has capacity, the provider may request that the principal consent to a medication other than that listed in the directive. A principal with capacity may always choose an alternative with no adverse effects on the future use of the directive.⁵⁴

4B.3.4 Obligation to Inquire About Directives

The federal Patient Self Determination Act, 42 U.S.C. § 1395cc(f), contains requirements for hospitals and nursing homes⁵⁵ pertaining to advance directives.⁵⁶ These requirements include providing education to all patients about advance directives, maintaining policies and procedures on advance directives, and inquiring on admission whether the patient has made an advance directive. Since Washington now explicitly recognizes mental health advance directives, these obligations likely extend to mental health advance directives as well as medical directives. The Medicare and Medicaid "Conditions of Participation" also contain similar requirements.⁵⁷

Providers who are licensed or certified by the Department of Social and Health Services under Chapter 71.24 RCW must advise clients of their right to make an advance directive regarding their physical and mental health.⁵⁸

⁴⁹ See RCW 71.32.150(5)(b).

⁵⁰ See RCW 71.32.150(6).

⁵¹ See RCW 71.32.070(1).

⁵² See RCW 71.32.070(2).

⁵³ For example, providers may submit an exception request to the payor, utilize free or discounted sources of medications such as pharmaceutical companies, or determine if the patient qualifies for the provider's charity care program.

⁵⁴ See RCW 71.32.080(7).

⁵⁵ See the preamble to the regulations implementing the Patient Self Determination Act (PSDA) at 60 FR 133262 (June 27, 1995) for a more complete description of which providers must comply with the PSDA requirements.

⁵⁶ See also 42 CFR Parts 417, 430, 431, 434, 483, and 489.

⁵⁷ See 42 CFR § 489.102.

⁵⁸ WAC 388-865-0410.

Volume 1: Patient Care Information, Treatment and Rights

4B.3.5 Immunities

Providers are not subject to civil liability or sanctions for unprofessional conduct under the Uniform Disciplinary Act (Chapter 18.130 RCW) when in good faith and without negligence:

- Treatment is provided in the absence of actual knowledge of the existence of a directive, or provided pursuant to a directive the provider does not know has been revoked;
- A principal is (or is not) determined to be incapacitated for the purpose of deciding whether to proceed according to a directive, or that determination is acted upon;
- Mental health treatment is (or is not) administered according to the principal's directive in good faith reliance on the validity of the directive and the directive is subsequently found to be invalid;
- Treatment is not provided according to one of the reasons authorized in RCW 71.32.150; or
- Treatment is provided according to the principal's directive.⁵⁹

While Washington law provides criminal immunity for compliance with a living will under the Natural Death Act (Chapter 70.122 RCW),⁶⁰ there is no such similar criminal immunity provided under Chapter 71.32 RCW. This disparity is not explained in the bill analyses or the statute.

4B.4 Inpatient Admission Pursuant to a Directive

Agents Appointed by a Directive Can Consent to Psychiatric Hospitalization and Treatment

An agent appointed under a directive can be given all of the patient's own authority to make inpatient psychiatric admission decisions.

4B.4.1 Process Requirements

Consent to inpatient admission in a directive is effective only if there is substantial compliance with the material provisions of the directive related to inpatient treatment.

If the admitting physician is not a psychiatrist, the principal must receive a complete psychological assessment by a mental health professional within twenty-four (24) hours of admission to determine the need for continued inpatient evaluation or treatment.⁶¹ If the principal is found to have capacity, he or she may only be admitted to or remain in inpatient treatment if he or she consents or is detained under the State's involuntary treatment laws (Chapter 71.05 RCW).⁶²

At the end of the period of time that the principal or his or her agent consented to voluntary inpatient treatment, but not longer than fourteen (14) days after admission, if the principal has not regained capacity or has regained capacity but refuses to consent to remain for additional treatment, the hospital must release the principal during reasonable daylight hours unless detained under the State's involuntary treatment laws.⁶³

If an incapacitated principal continues to refuse inpatient treatment, he or she may seek injunctive relief from a court.⁶⁴

⁵⁹ See RCW 71.32.170.

⁶⁰ See RCW 9A.42.040 (compliance with a living will does not qualify as criminal mistreatment under Chapter 9A.42 RCW).

⁶¹ See RCW 71.32.140(3).

⁶² See RCW 71.32.140(4)(a).

⁶³ See RCW 71.32.140(5).

⁶⁴ See RCW 71.32.140(4)(b).

A principal who is voluntarily admitted under the directive statute has all the rights provided to individuals voluntarily admitted to inpatient treatment under Chapters 71.05 (Adult Mental Health), 71.34 (Minor Mental Health),⁶⁵ 72.23 (Public and Private Facilities for Mentally Ill) RCW with the following exception: if a principal takes action demonstrating a desire to be discharged, and makes statements requesting to be discharged, the principal shall be allowed to be discharged and may not be restrained in any way in order to prevent his or her discharge.⁶⁶

4B.4.2 When Principal Refuses to be Admitted

The following applies to a principal who:

- Chose not to be able to revoke his or her directive during any period of incapacity;
- Consented to voluntary admission to inpatient mental health treatment or authorized an agent to consent on the principal's behalf in his or her directive; and
- At the time of admission to inpatient treatment, refuses to be admitted.

For a hospital to admit the principal pursuant to the directive, a physician member of the hospital medical staff must:

- Evaluate the principal's mental condition and determine in conjunction with another health care provider or mental health professional that the principal is incapacitated;
- Obtain the informed consent of the agent, if any, designated in the directive;
- Document that the principal needs an inpatient evaluation or is in need of inpatient treatment and that the evaluation or treatment cannot be accomplished in a less restrictive setting; and
- Document in the medical record a summary of findings and recommendations for treatment or evaluation.⁶⁷

4B.4.3 Long Term Care Facilities

RCW 71.32.250 contains requirements for readmission to long-term care facilities after a psychiatric inpatient admission.

4B.4.4 Guardians' Ability to Admit Patients

Nothing in Chapter 71.32 RCW eliminates the restrictions on the authority of guardians found in the Guardianship Chapter (Chapter 11.92 RCW).

4B.5 Capacity Determinations Process

If the principal has chosen to have the directive become effective when he or she becomes incapacitated or when the circumstances, symptoms or behaviors indicated in the directive occur, a provider must evaluate the individual for both the presence of those indicators and for capacity. Only if the principal is incapacitated and the listed circumstances are present may the provider rely upon the directive as authority. This could result in a patient being incapacitated, yet because particular circumstances, symptoms, or behavior are not present, the directive is not effective.

4B.5.1 Who May Request a Determination

For purposes of effectuating the requirements of Chapter 71.32 RCW, a principal, agent, professional person, or health care provider may seek a determination of whether the principal is incapacitated or has regained

⁶⁵ Although RCW 71.32.050(1) states that only an adult (including an emancipated minor) may execute a directive, RCW 71.32.140(4)(a) refers to Chapter 71.34 RCW, the Minor Mental Health Statute.

⁶⁶ See RCW 71.32.140(6).

⁶⁷ See RCW 71.32.140(2).

Volume 1: Patient Care Information, Treatment and Rights

capacity.⁶⁸ Once a principal with a directive has been determined to be incapacitated, his or her directive becomes operational.

4B.5.1.1 Requests by a Professional Person or a Health Care Provider

If a professional person or health care provider is seeking a capacity determination, that person must promptly inform the principal that he or she is requesting the determination and the principal may request a court make the determination.⁶⁹

4B.5.2 Who May Make a Determination

For purposes of a directive, a capacity determination may only be made by:

- A court, if the request is made by the principal or the principal's agent;
- One mental health professional and one health care provider; or
- Two health care providers.⁷⁰

If a court does not make the determination, one of the persons making the determination must be a psychiatrist, psychologist, or psychiatric advanced registered nurse practitioner.⁷¹

At least one mental health professional⁷² or health care provider⁷³ must personally examine the principal prior to making a capacity determination.⁷⁴

4B.5.3 Determination by a Court

If the principal chooses a capacity determination by a court:

- A mental health provider familiar with the principal must testify, and
- The principal must be given the opportunity to appear in court prior to the determination.⁷⁵

4B.5.4 Capacity Determination Time Frames and Obligations

A determination of capacity must be completed within forty-eight (48) hours when a request for an initial determination of capacity is made by a principal, agent, professional person or a health care provider.⁷⁶ During the period between the request and the completion of the determination, the principal may not be treated unless consent is given, or state or federal law otherwise authorizes treatment.⁷⁷

⁶⁸ See RCW 71.32.110(1).

⁶⁹ See RCW 71.32.110(3).

⁷⁰ See RCW 71.32.110(2)(a).

⁷¹ See RCW 71.32.110(2)(b).

⁷² See RCW 71.32.010(12).

⁷³ See RCW 71.32.020(6).

⁷⁴ To determine incapacity, providers should start with their standard policies and procedures for determining competence to provide informed consent, and modify those policies and procedures to include the timeframes, notice of right to have the determination made by a court, and inclusion of the required professionals as indicated by RCW 71.32.110 and RCW 71.32.130.

⁷⁵ See RCW 71.32.110(5)(a).

⁷⁶ See RCW 71.32.130(1).

⁷⁷ Id.

If an incapacitated person is already being treated according to his or her directive, a request for redetermination of capacity does not prevent treatment while the redetermination is pending.⁷⁸

4B.5.4.1 Inpatient Treatment

When an incapacitated principal is admitted to inpatient treatment pursuant to the provisions of his or her directive, capacity must be reevaluated within seventy-two (72) hours of admission or when there has been a change in the principal's condition that indicates he or she appears to have regained capacity, whichever occurs first.⁷⁹ After seventy-two (72) hours of inpatient treatment, capacity must again be reevaluated when there has been a change in the principal's condition that indicates he or she appears to have regained capacity.⁸⁰

Any requests for redeterminations made by the principal or his or her agent, must be completed within seventy-two (72) hours of the request.⁸¹

If a principal who does not have an agent for mental health treatment decisions is being treated in an inpatient facility and requests a determination or redetermination of capacity, the mental health professional or health care provider must complete the determination or, if the principal is seeking a determination from a court, must make reasonable efforts to notify the person authorized to make decisions for the principal under the Informed Consent provision of RCW 7.70.065.⁸²

4B.5.4.2 Outpatient Treatment

When a principal who has been determined to be incapacitated is being treated on an outpatient basis and there is a request for a redetermination of his or her capacity, the redetermination must be made within five (5) days of the first request following a determination.⁸³ When a principal who does not have an agent for mental health treatment decisions is being treated on an outpatient basis, the person requesting a capacity determination must arrange for the determination.⁸⁴

4B.5.4.3 Failure to Meet Time Frames for Capacity Determination

With respect to both inpatient and outpatient treatment, if a capacity determination (including a redetermination) is not made within the required time frames, the principal shall be considered to have capacity and shall be treated accordingly.⁸⁵ There are no provisions in the statute for an extension of these timeframes.⁸⁶ This includes a request by the principal that a court make the determination.

4B.5.5 Duty of Agent

When a principal with an agent for mental health treatment decisions requests a determination or redetermination of capacity, the agent must make reasonable efforts to obtain the determination or redetermination.⁸⁷

⁷⁸ See RCW 71.32.130(5).

⁷⁹ See RCW 71.32.130(2)(a)(i).

⁸⁰ See RCW 71.32.130(2)(a)(ii).

⁸¹ See RCW 71.32.130(2)(a)(iii).

⁸² See RCW 71.32.130(3)(b).

⁸³ See RCW 71.32.130(2)(b).

⁸⁴ See RCW 71.32.130(3)(c).

⁸⁵ See RCW 71.32.130(4).

⁸⁶ In the case of potential discharge against medical advice, providers may wish to consider whether the principal meets criteria for detention under the State's involuntary treatment laws (Chapter 71.05 RCW).

⁸⁷ See RCW 71.32.130(3)(a).

Volume 1: Patient Care Information, Treatment and Rights

4B.5.6 Payment of Capacity Determinations

Who pays for all the capacity determinations and redeterminations? There is no discussion in the statute regarding public funding for capacity determinations or redeterminations. Nor was funding appropriated by the Washington State Legislature to cover these costs. The statute makes clear, however, that providers are not required to assume the costs associated with treatment.⁸⁸ Nor does a directive create an entitlement to treatment or supersede a determination of medical necessity.⁸⁹

Whether these evaluations are to be paid for by private or governmental payors turns on whether they are medically necessary. A capacity determination at the time of admission may be considered part of the evaluation for admission. Similarly, redeterminations based on a change in condition of the principal may be medically necessary. Other capacity determinations or redeterminations requested by the principal or agent, as well as court hearings and testimony, may not be determined to be medically necessary.⁹⁰

The statute makes no mention of funding for court costs, including filing fees or counsel for the principal. No funding was provided to courts for implementation of capacity hearings and it is unclear whether courts will hear these requests along with civil commitment hearings, in probate court with guardianships, or some other venue.

4B.6 Directives and the Involuntary Civil Commitment Process

A directive does not limit any authority otherwise provided in Titles 10 (Criminal Procedure), 70 (Public Health and Safety), 71 (Mental Illness) RCW, or any other applicable state or federal law that allows the detention, commitment, or involuntary treatment of an individual.⁹¹

If a principal is involuntarily detained or committed for involuntary treatment and provisions of the directive are inconsistent with either the purpose of the detention or commitment or any court order relating to the commitment, those provisions may be treated as invalid during the detention or commitment. The remaining provisions of the directive are advisory, however, while the principal is detained or committed.⁹²

This does not mean that providers of involuntary treatment should ignore directives. The information contained in a directive has the potential to be of substantial benefit to providers. A directive can assist providers in managing the principal's inpatient stay and designing a patient-driven treatment plan. A directive may include information regarding behavioral and medical interventions that have succeeded or failed in the past, alleviating the need for trials of therapies known not to work. The directive statute therefore encourages involuntary treatment providers to respect the provisions of a directive even when it is not binding.⁹³

One provision of Chapter 71.32 RCW departs from normal practice under the State's involuntary treatment laws (Chapter 71.05 RCW). Under RCW 71.05.050 a voluntary patient is to be discharged immediately upon request. However, the provision allows a provider to detain the patient for sufficient time to obtain an evaluation of the individual by a designated mental health professional.⁹⁴ Chapter 71.32 RCW clearly changes the standard for

⁸⁸ See RCW 71.32.070(2).

⁸⁹ See RCW 71.32.070(1) and (2).

⁹⁰ For principals receiving publicly funded healthcare coverage, providers are advised to contact their regional support networks and the Department of Social and Health Services regarding questions of payment.

⁹¹ See RCW 71.32.240.

⁹² See RCW 71.32.150(3).

⁹³ See RCW 71.32.150(3)(b).

⁹⁴ See RCW 71.05.050.

discharge of a voluntary patient admitted via consent in his or her directive from mere verbal expression to verbal expression as well as deliberate action towards discharge. Whether this provision also eliminates providers' ability to detain such an individual (in order to obtain evaluation by a designated mental health professional) is unclear.

4B.7 Resources for Assistance

- Washington State Hospital Association

www.wsha.org/MentalHealth.htm

Includes links to a sample policy, clinician checklist, educational power point presentation, patient information brochure, and other materials intended for use by WSHA's member hospitals.

- The Department of Social and Health Services, Mental Health Division

www.dshs.wa.gov/mentalhealth/index.htm

- The Bazelon Center for Mental Health Law

www.bazelon.org/issues/advancedirectives/index.htm

While not Washington specific, this site has general information regarding directives and their use across the country.