Washington Health Law Manual — Fourth Edition

Washington State Society of Healthcare Attorneys (WSSHA)

Chapter 9: Mental Health Advance Directives

Authors:

Lori Oliver, JD, MBA
Organization: Polsinelli

Jim Fredman, JD, LLM
Organization: Polsinelli

Ryan Mize, JD
Organization: Polsinelli

Previous Version Authors:

Kristin Miles, JD
Rohana Fine, JD

For reference purposes, this chapter was prepared from laws, cases, and materials selected by the authors, which were available as of June 1, 2021.

Biographies

Lori Oliver, JD, MBA

Lori Oliver is a shareholder in the Seattle Office of Polsinelli, PC where she partners with healthcare organizations to develop and implement strategies to promote business success in today's constantly changing healthcare industry. Lori's legal practice focuses on a wide array of health care regulatory, transactional and operational matters. Prior to joining Polsinelli, Ms. Oliver served as an Associate Vice President for UW Medicine and an Assistant Attorney General representing the University of Washington and UW Medicine. She received her B.A. from Boise State University, her MBA from the Atkinson Graduate School of Management and her J.D. from Willamette University, where she also served as Editor-in-Chief of the Willamette Law Review.

Jim Fredman, JD, LLM

Jim Fredman is a healthcare shareholder who practices in Polsinelli's Seattle office. Jim focuses his practice on the general representation of healthcare providers, including, hospitals, academic medical centers, research organizations, pharmacies, clinically integrated networks, behavioral health providers and ambulatory surgery centers providing practical advice on a wide range of regulatory, operational and transactional matters. Jim received his B.A. from the University of Oklahoma, his J.D. from the University of Tulsa, and his L.L.M in healthcare law from DePaul University College of Law. Jim was selected for inclusion in The Best Lawyers in America® for Health Care Law, 2020, 2021.

Ryan Mize, JD

Ryan Mize is an associate in the Kansas City office of Polsinelli PC and a member of the firm's health care department. Ryan's practice focuses on advising health systems, hospitals, behavioral health organizations, and other providers on general compliance, fraud and abuse, licensure, enrollment, and reimbursement matters. In particular, he frequently uses his experience in these areas to assist clients with structuring transactions and navigating regulatory issues that arise during the deal process. He received his B.A., M.H.S.A., and J.D. from the University of Kansas.

CHAPTER OUTLINE

9.1 Introduction

An advance directive allows competent individuals to express their preferences about future medical treatment in the event the individual becomes incapacitated and unable to make such decisions. Sometimes referred to as a "living will," advance directives are typically used to specify the circumstances in which the individual would want medical treatment withdrawn or withheld. Advance directives often incorporate or accompany a durable power of attorney for health care, which authorizes an attorney-in-fact to provide informed consent for health care decisions on the incompetent principal's behalf, or the nomination of a guardian for consideration by the court if guardianship proceedings are commenced.

In 2003, the Washington State Legislature passed Washington's first law governing advance directives for mental health treatment.[1] Codified at Chapter 71.32 RCW, the statute is based on the fundamental premise that an individual with capacity has the ability to control decisions related to the individual's mental illness and is intended to provide a legal mechanism to express preferences for mental health treatment during periods of incapacity.

While this chapter's primary focus is Washington's mental health advance directive statute, providers and affected entities must be mindful of their obligations under not only this statute, but also the other federal and state laws that impose provider obligations related to advance directives generally, and encompass mental health advance directives. These laws are discussed in Section 9.2 below.

In addition, providers should remember to give consideration to any obligations arising under other Washington laws affecting the decision-making authority one can have over an individual and the individual's affairs. Many of these laws have recently been adopted or amended, including the Uniform Power of Attorney Act adopted in 2016, the Involuntary Treatment Act amended in 2020, and the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act adopted in 2019 and amended in 2020.

9.2 General Provider Requirements Related to Advance Directives

9.2.1. Federal Law

The federal Patient Self Determination Act, 42 U.S.C. § 1395cc(f) ("PSDA"), contains advance directive requirements for Medicare-participating hospitals, nursing homes, home health agencies, hospice programs, and Medicare Advantage and Medicaid managed care plans. The PSDA requires these providers and organizations to provide information to all patients about their individual rights under State law to make decisions concerning medical

[1] At the time legislation was enacted 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. Today, at least 25 states have laws that support the use of mental health advance directives. 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 was and remains one of the broader approaches, and requires careful implementation by affected entities.

care, including the right to formulate advance directives, maintain policies and procedures on advance directives, inquire on admission whether the patient has made an advance directive, and document any directives in the patient's medical record. Since Washington recognizes mental health advance directives, these obligations extend to mental health advance directives as well as medical directives. The Medicare "Conditions of Participation" that implement the PSDA further expand on provider advance directive obligations, which include updating the written information given to patients about their advance directive rights under State law no later than 90 days from the effective date of any change in the State's laws.[2]

The federal government continues to emphasize the use of advance directives and, specifically, psychiatric advance directives. For example, the criteria for the demonstration program to establish Certified Community Behavioral Health Clinics (CCBHCs) that was part of the Protecting Access to Medicare Act of 2014 included the use of psychiatric advance directives by a CCBHC as part of its crisis management services, care coordination, and person-centered treatment planning.[3]

9.2.2. Washington Law

Patterned after the requirements of the federal PSDA, Washington law requires agencies, health maintenance organizations, and facilities (such as hospitals, skilled nursing facilities and providers of in-home care) who serve medical assistance clients to comply with substantially similar requirements.[4]

In addition, all entities that are licensed or certified by the Department of Health to provide behavioral health services must advise Medicaid patients of their right to make an advance directive regarding their physical and mental health.[5] Mental health inpatient providers who are licensed to provide evaluation and treatment services or crisis stabilization unit services must establish policies and procedures to ensure the rights of individuals to make mental health advance directives, and establish protocols for responding to individual and agent requests consistent with RCW 71.32.150.[6]

9.3 Contents and Scope of the Directive

9.3.1. 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 and

[2] 42 CFR 489.102(a)(1)(i).

[3] *See* Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (accessible at https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf).

[4] WAC 182-501-0125.

[5] WAC 246-341-0600(4); WAC 182-538-180; WAC 182-501-0125.

[6] WAC 246-341-1134(1)(b)(iii); 246-341-1140(4)(h)-(i).

preferences regarding the individual's mental health treatment, (b) designate a surrogate decision maker to make mental health treatment decisions on the individual's 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 statutes such as the Natural Death Act (Chapter 70.122 RCW) and the Uniform Power of Attorney Act (Chapter 11.125 RCW), there are enough key distinct definitions to warrant a review of the definition Section of the directive statute. RCW 71.32.020 contains the complete list of statutory definitions specific to Chapter 71.32 RCW but for purposes of what is included, the term "mental disorder" includes *any* organic, mental, or emotional impairment that has substantial adverse impact on an individual's cognitive or volitional functions.[7]

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 the individual's family avoid the civil commitment process in the event psychiatric hospitalization or medication is needed.[8]

9.3.2. Scope of Directive

An adult with capacity may execute a directive as the "principal".[9] Capacity means that the adult has not been found to be incapacitated pursuant to the mental health advance directive statute or subject to a guardianship under RCW 11.130.265. 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.[10] The directive may contain:

- Preferences and instructions for mental health treatment;
- Consent to specific types of mental health treatment;

[7] RCW 71.32.020(10). Mental disorders are a subset of behavioral health disorders, as defined in RCW 71.05.020, which also includes substance use disorders which are a cluster of cognitive, behavioral and physiological symptoms indicating that an individual continues to use a substance despite significant substance-related problems. See RCW 71.05.020(7), (37) and (52).

[8] 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(1) and RCW 11.125.400(3). 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 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.

[9] See RCW 71.32.020(13).

[10] See RCW 71.32.050(3).

- 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.[11]

9.3.3. 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 writing[12] and in substantially the same form as the model directive.[13] The sections of the model directive are described below and the Washington State Health Care Authority maintains a mental health advance directive form on its website at https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-advance-directives#where-get.

Part I. Statement of Intent

As required by RCW 71.32.060, the mental health directive must contain language clearly indicating the principal's intent to create a directive.

Part II. When the Directive is Effective

The principal may designate in the directive when it is to become effective.[14] The model directive provides the following three options:

- Immediately upon signing the directive;
- When the principal becomes incapacitated; or

[11] See RCW 71.32.050.

[12] See RCW 71.32.060(1)(a).

[13] 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.

[14] See RCW 71.32.060.

- 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.[15]

Part III. 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.

Part IV. Terms of Revocation

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

Part V. Treatment Preferences and Instructions

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

- Provide preferences for treating physicians and other providers to be involved in care;
- Identify physicians or other providers by whom the principal does not want to be involved in their care;
- 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

[15] Id.

- Specify who may not visit during treatment and provide general instructions about how the principal can be best helped by treatment staff.

Note that a directive can contain advance consent through an individual's signature that satisfies informed consent requirements for psychiatric hospitalization or medication.[16]

The fact that a patient has executed a directive does not mean the person is not capable of providing informed consent.[17]

Part VI. 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 the principal's ability to revoke the agency appointment.

- Nominate a person to act as a court appointed guardian.

Part VII. Other Documents

The model directive provides an opportunity for the principal to identify whether the principal 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.[18]

Part VIII. Notification of Others and Care of Personal Affairs

The model directive contains a Section in which the principal may give direction to the principal's agent regarding notification of designated individuals once the directive becomes effective and preferences and instructions regarding personal affairs such as care of dependents, pets, and household matters.

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.[19]

Part IX. 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.[20] If the principal is unable to sign, it must be signed

[16] RCW 71.32.260.

[17] See RCW 71.32.210.

[18] See RCW 71.32.180.

[19] See RCW 71.32.070(3).

[20] See RCW 71.32.060.

at the principal's direction in the presence of the principal.[21] While not addressed in the statute, best practice when signing at the direction of the principal is to include the name of the person signing at the direction of the principal. In order to be a witness, the individual must attest that the witness personally knows the principal, the principal 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. The following individuals may not be witnesses: [22]

- 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 relationship;[23]
- A person who is declared to be an incapacitated person;
- A person who would benefit financially if the principal making the directive undergoes mental health treatment; or
- A minor.

Part X. Record of Directive

Describes the persons to whom the principal has given a copy of the directive.

Part XI. Revocation of Directive

The principal may revoke parts of the directive or the directive in its entirety.

[21] See RCW 71.32.060.

[22] See RCW 71.32.090.

[23] Dating relationship is defined by reference to RCW 26.50.010 and means a social relationship of a romantic nature. Courts may consider three factors in determining such a relationship exists: (a) the length of time the relationship has existed; (b) the nature of the relationship; and (c) the frequency of interaction between the parties.

9.3.4. 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 the principal's directive was executed;
- Be used as the authority for inpatient admission for more than fourteen (14) days in any twenty-one (21) day period;[24] or
- Obligate any healthcare provider, professional or healthcare facility to provide care that would violate accepted standard of care.[25]

9.3.5. 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 Uniform Power of Attorney Act (Chapter 11.125 RCW) and the Informed Consent Statute (RCW 7.70.065) apply unless specifically superseded by a provision in Chapter 71.32 RCW.[26] The directive must also indicate whether the principal's intent that the authority given to the agent shall be exercised regardless of the principal's incapacity.[27]

If the principal designates an agent in the directive, the principal must notify the agent in writing of the appointment.[28]

---

[24] See RCW 71.32.070.

[25] RCW 71.32.150(2).

[26] See RCW 71.32.100(1).

[27] See RCW 71.32.060.

[28] See RCW 71.32.100(2).

9.3.5.1 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.[29]

9.3.5.2 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.[30]
- The principal may revoke an agency appointment according to state law, unless the durable power of attorney provides otherwise.[31]

9.3.6. Revocation of the Directive

Whether a principal may revoke the principal's directive during periods of incapacity depends on the choice the principal made at the time the directive was executed.[32] 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.[33] A principal may also specify under

[29] See RCW 71.32.100.

[30] See RCW 71.32.100(8).

[31] See RCW 71.32.100(9).

[32] See RCW 71.32.080; RCW 71.32.260

[33] See RCW 71.32.060(1)(d).

which circumstances the principal wishes to be able to revoke the appointment of an agent.[34]

9.3.6.1 When a Directive May be Revoked

A principal with capacity may revoke a directive in whole or in part by written statement.[35] An incapacitated principal may revoke only if the principal elected to be able to revoke when incapacitated at the time of executing the directive.[36]

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.[37]

9.3.6.2 Procedures for Revocation

A revocation must be in writing, although it need not take any specific form.[38] 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.[39] In the case of a directive that is stored in the Washington healthcare declarations registry, the revocation may be done by an online method but failure to use the online method does not invalidate a revocation.[40] The registry was established by the Washington Department of Health pursuant to legislation enacted in 2006, which allowed the department to contract with an organization to create and maintain the registry database. In 2007, the department contracted with the U.S. Living Will Registry for that purpose, but the Washington legislature defunded the registry effective June 30, 2013. Individuals who previously registered and provided health care declaration documents are able to access them through U.S. Living Will Registry.

9.3.6.3 When a Revocation is Effective

In order to revoke the principal's 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.[41] The statement of revocation is effective as to a health care provider,

[34] See RCW 71.32.100(9).

[35] See RCW 71.32.080(1)(a).

[36] See RCW 71.32.080(1)(b).

[37] RCW 71.32.080(6).

[38] See RCW 71.32.080(2).

[39] See RCW 71.32.080(5)(a).

[40] RCW 71.32.080(2); see also RCW 70.122.130.

[41] See RCW 71.32.080(3).

professional person, or health care facility upon receipt and must be made a part of the medical record.[42]

As to the principal's agent, revocation is also effective upon receipt by the agent.[43] 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.[44]

9.3.6.4 Revocation by Court Order

A directive may be superseded or revoked by a court order, including an order entered in a criminal matter.[45]

9.3.6.5 Waiver

When a principal with capacity consents to treatment that differs from, or refuses treatment consented to in the provisions of the principal's 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.[46]

9.4 Provider Responsibilities and Immunities

9.4.1. Who Must Comply with the Statute

Health care providers, professional persons and health care facilities are required to comply with a valid directive.[47] 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.[48] Please consult RCW 71.32.020 for the statutory definitions of the providers and entities required to follow this chapter.

9.4.2. 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.[49] Although not required by the statute, providers should have policies and procedures in place to review directives when they are first

[42] See RCW 71.32.080(4)(a).

[43] See RCW 71.32.080(4)(b).

[44] Id.

[45] See RCW 71.32.080(5)(b).

[46] RCW 71.32.080(7).

[47] See RCW 71.32.020 for definitions of categories of providers and facilities.

[48] See RCW 71.32.150.

[49] See RCW 71.32.150(1).

presented as the provider will be deemed to have actual knowledge of the directive's content.

9.4.2.1 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 the principal's agent, must be notified of the objection and the reason must be documented in the principal's medical record.[50] 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.[51]

9.4.2.2 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.[52]

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 the principal's agent, must be notified and the reason documented in the medical record.[53] All other parts of the directive shall be followed.[54]

9.4.3. No Entitlement to Treatment

A directive does not create an entitlement to treatment[55] nor are providers obligated to assume the costs of the treatment requested.[56] Although a principal may specify physician

[50] See RCW 71.32.150(5)(a).

[51] See RCW 71.32.150.

[52] See RCW 71.32.150(2).

[53] See RCW 71.32.150(5)(b).

[54] See RCW 71.32.150(6).

[55] See RCW 71.32.070(1).

[56] See RCW 71.32.070(2).

preferences in the principal's directive, as with patients in any care setting, this does not mean that a principal may choose any physician the principal 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 the principal unavailable to the requesting patient.

Similarly, a principal may indicate in the principal's 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 the principal's insurance, or when a principal is uninsured.[57] 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.[58]

9.4.4. Obligation to Inquire About Directives

As discussed in Section 9.2, above, Medicare and Medicaid participating providers are required to document in the patient's medical record whether or not the person has executed an advance directive.

9.4.5. 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

[57] 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.

[58] See RCW 71.32.080(7).

- 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] no such immunity is provided under Chapter 71.32 RCW. This disparity is not explained in the bill analyses or the statute.

9.5 Inpatient Admission Pursuant to a Directive

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

9.5.1. 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.

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 RCW (Adult Mental Health), 71.34 RCW (Minor Mental Health),[61] and 72.23 RCW (Public and Private Facilities for Mentally Ill), 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 the principal's discharge.[62]

9.5.2. When Principal Refuses to be Admitted

The following applies to a principal who:

- Chose not to be able to revoke the principal's 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 the principal's directive; and
- At the time of admission to inpatient treatment, refuses to be admitted.

[59] See RCW 71.32.170.

[60] See RCW 70.122.051(2). RCW 9A.42.040 (compliance with a living will does not qualify as criminal mistreatment under Chapter 9A.42 RCW).

[61] 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.

[62] See RCW 71.32.140(6).

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.[63]

    - 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.[64] If the principal is found to have capacity, the principal may only be admitted to or remain in inpatient treatment if the principal consents or is detained under the State's involuntary treatment laws (Chapter 71.05 RCW).[65]

    - At the end of the period of time that the principal or the principal's 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.[66]

    - If a principal who is determined by two health care providers or one mental health professional and one health care provider continues to refuse inpatient treatment, the principal may seek injunctive relief from a court.[67] If the principal is seeking a determination from the court, the health care provider must make reasonable efforts to notify the person authorized to make decisions for the principal of the principal's request.[68]

[63] See RCW 71.32.140(2).

[64] See RCW 71.32.140(3).

[65] See RCW 71.32.140(4)(a).

[66] See RCW 71.32.140(5).

[67] See RCW 71.32.140(4)(b)

[68] RCW 71.32.130(3)(b).

9.5.3. Readmission to Long Term Care Facilities

RCW 71.32.250 contains requirements for readmission to long-term care facilities after a psychiatric inpatient admission. For a principal who is a resident of a long-term care facility and admitted to inpatient mental health treatment pursuant to the principal's directive, the principal must be allowed to be readmitted to the same long-term care facility as if the inpatient admission had been for a physical condition when (i) the treating facility's professional staff determines that inpatient mental health treatment is no longer medically necessary or (ii) the principal's consent to admission in the principal's directive has expired.[69] These requirements apply regardless of whether the inpatient mental health treatment of the resident is directly from a facility, hospital emergency room, or other location. If the long-term care facility does not have a bed available at the time of discharge, the treating facility may discharge the resident, in consultation with the resident and agent if any, and in accordance with a medically appropriate discharge plan, to another long-term care facility.

9.5.4. Guardianship

For a full discussion of the role of guardianship in medical decision making, please see Chapter 2, Washington State Health Law Manual, Fourth Edition, Consent to Care: Healthcare Decision Making for Incompetent Patients, and Chapter 11.92 RCW.

9.6 Capacity Determination Process

If the principal has chosen to have the directive become effective when the principal 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.

9.6.1. 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 capacity.[70] Once a principal with a directive has been determined to be incapacitated, the principal's directive becomes operational.

[69] RCW 71.32.250(1).

[70] See RCW 71.32.110(1).

9.6.1.1 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 the principal is requesting the determination and the principal may request a court make the determination.[71]

9.6.2. 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.[72]

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.[73]

At least one mental health professional[74] or health care provider[75] must personally examine the principal prior to making a capacity determination.[76]

9.6.3. 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 (which can be telephonically if allowed by local court rules) prior to the determination.[77]

[71] See RCW 71.32.110(3).

[72] See RCW 71.32.110(2)(a).

[73] See RCW 71.32.110(2)(b).

[74] See RCW 71.32.020(12).

[75] See RCW 71.32.020(6).

[76] 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.

[77] See RCW 71.32.110(5)(a).

9.6.4. 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.[78] 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.[79]

If an incapacitated person is already being treated according to the principal's directive, a request for redetermination of capacity does not prevent treatment while the redetermination is pending.[80]

9.6.4.1 Inpatient Treatment

When an incapacitated principal is admitted to inpatient treatment pursuant to the provisions of the principal's 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 the principal appears to have regained capacity, whichever occurs first.[81] 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 the principal appears to have regained capacity.[82]

Any requests for redeterminations made by the principal or the principal's agent, must be completed within seventy-two (72) hours of the request.[83]

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.[84]

9.6.4.2 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 the principal's capacity, the redetermination must be made within five (5) days of the first request

[78] See RCW 71.32.130(1).

[79] See RCW 71.32.130(1).

[80] See RCW 71.32.130(5).

[81] See RCW 71.32.130(2)(a)(i).

[82] See RCW 71.32.130(2)(a)(ii).

[83] See RCW 71.32.130(2)(a)(iii).

[84] See RCW 71.32.130(3)(b).

following a determination.[85] 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.[86]

9.6.4.3 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.[87] There are no provisions in the statute for an extension of these timeframes.[88] This includes a request by the principal that a court make the determination. However, the statute is ambiguous on how the process works and in the absence of case law, a discussion with legal counsel may be advisable.

9.6.5. 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.[89]

9.6.6. Payment of Capacity Determinations

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.[90] Nor does a directive create an entitlement to treatment or supersede a determination of medical necessity.[91]

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.

---

[85] See RCW 71.32.130(2)(b).

[86] See RCW 71.32.130(3)(c)

[87] See RCW 71.32.130(4).

[88] 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).

[89] See RCW 71.32.130(3)(a).

[90] See RCW 71.32.070(2).

[91] See RCW 71.32.070(1) and (2).

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.

9.7 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.[92]

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.[93]

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.[94]

9.8 Conclusion

An advance directive is an important exercise of autonomy that allows competent individuals to express their preferences about future medical treatment to provide direction in the event the individual becomes incapacitated and unable to make such decisions. In 2021, the Washington Legislation refreshed the 2003 law to reflect the expanded circumstances of when an advance directive might be used through adding new definitions for behavioral health disorders and substance use disorders in addition to the existing definition of mental disorders. These definitional changes are an important step in expanding the scope and usefulness of directives to provide preferences and instructions in the event of an individual's incapacity resulting from a breadth of behavioral health disorders, not just mental disorders and aligning with other existing statutory definitions. Further, expanding the scope of the law to persons who are at least 13 years of age when the person is capable of making informed decisions related to behavioral health care is another step in increasing the use of this important tool to express an individual's wishes and provide key information for clinicians.

[92] See RCW 71.32.240.

[93] See RCW 71.32.150(3).

[94] See RCW 71.32.150(3)(b).

Appendix

Resources for Assistance as of Publication Date (*some are not yet updated for changes in the 2021 legislative session)

- Washington State Hospital Association (*https://www.wsha.org/our-members/projects/end-of-life-care-manual/*). 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.

- Washington State Health Care Authority (*https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-advance-directives#where-get*). This site is a resource for consumers to access an informational brochure on mental health directives and the model form.

- The Bazelon Center for Mental Health Law (*http://www.bazelon.org/our-work/mental-health-systems/advance-directives/*). While not Washington specific, this site has general information regarding directives and their use across the country.

- National Resource Center on Psychiatric Advance Directives (*https://www.nrc-pad.org/*). A joint project of the Bazelon Center and Duke University, NRC-PAD's site provides state by state information on the legal status of mental health advance directives and guidance for their implementation.