Department of Mental Health

TRANSMITTAL LETTER

SUBJECT **Advance Directives**		
POLICY NUMBER **DMH Policy 515.1**	DATE AUG 3 1 2004	TL# 55

Purpose. To establish the Department of Mental Health (DMH) policy and procedures governing the use of advance directives regarding health care treatment decisions, including mental health treatment, and provide sample forms that may be used to create a living will, durable power of attorney for health care, and advance instructions for mental health care.

Applicability. Applies to all private and public providers of mental health services and supports, including the public core services agency and Saint Elizabeths Hospital. See Section 10 of the policy for community residential facilities (CRFs).

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

Implementation Plans. A plan of action to implement or adhere to this policy must be developed by designated responsible staff. If materials and/or training are required to implement this policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. ***Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed within sixty (60) days after the date of this policy.***

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must file this policy in the **DMH** Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

*If any CMHS or DMH policies are referenced in this policy, copies may be obtained from the DMH Policy Support Division by calling (202) 673-7757.

ACTION

REMOVE AND DESTROY	INSERT
CMHS Policy 50000.515.4B,Patient's Advance Directives, dated 12/12/96, and CMHS Policy 50000.515.5, Consumer Statement of Treatment Preferences, dated 03/23/00	**DMH Policy 515.1**

Martha B. Knisley
Director, DMH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH	Policy No. 515.1	Date AUG 3 1 2004	Page 1
	Supersedes: CMHS Policy 50000.515.4B, Patient's Advance Directives, dated 12/12/96; and CMHS Policy 50000.515.5, Consumer Statement of Treatment Preferences, dated 03/23/00		

Subject: Advance Directives

1. **Purpose**. To establish the Department of Mental Health (DMH) policy and procedures governing the use of advance directives regarding health care treatment decisions, including mental health treatment.

2. **Applicability**. Applies to all private and public providers of mental health services and supports, including the public core services agency and Saint Elizabeths Hospital. See Section 10 below for community residential facilities (CRFs).

3. **Authority**. Mental Health Service Delivery Reform Act of 2001; and Chapter 1 of Title 22A, DCMR, Consent to Treatment.

4. **Definitions**. For the purpose of this policy:

4a. Advance Directives. A written document signed by a consumer that indicates what decision(s) a consumer would make if he/she in the future cannot make his/her wishes known about health care treatment decisions, including mental health treatment.

Advance directives may be in the form of any, or all of the following:

- Living Will (also see Section 4b below and Exhibit 1);
- Durable Power of Attorney for Health Care (also see Section 4c below and Exhibit 2), and/or
- Advance Instructions (also see Section 4d below and Exhibit 3).

4b. Living Will. A document prepared by a consumer in accordance with the Natural Death Act of 1981 (D.C. Official Code § 7-621 et seq.), which sets forth the consumer's wishes regarding application or withdrawal of life sustaining procedures when the consumer is in imminent danger of death.

4c. Durable Power of Attorney for Health Care. A written document prepared by a consumer that designates an individual as the attorney-in-fact, and empowers that individual to make health care treatment decisions on behalf of the consumer when he/she is unable to make such decisions.

- A durable power of attorney for health care becomes effective when the consumer is deemed incapacitated, under the District of Columbia Health Care Decisions Act of 1988 (D.C. Official Code § 21-2201 et seq.).

- The durable power of attorney shall be honored by the consumer's attorney-in-fact in accordance with D.C. Official Code § 21-2206(c)(1), or by any substitute health care decision maker in accordance with D.C. Official Code § 21-2110(b). This document must be signed by two witnesses who cannot be employees of the health care provider(s).

4d. Advance Instructions. A written document prepared in accordance with D.C. Official Code § 7-1231.06 and Chapter 1 of Title 22A, DCMR, that details a consumer's mental health treatment preferences including his/her informed choice to accept or forego particular mental health services and mental health supports. Advance instructions become effective when the consumer is certified as incapacitated.

4e. Incapacitated Individual. As defined in the Health Care Decision Act: An adult individual who lacks sufficient mental capacity to appreciate the nature and implications of a health-care decision, make a choice regarding the alternatives presented, or communicate that choice in an unambiguous manner.

4f. Attorney-in-Fact. A person who has been appointed by a consumer to make health care treatment decisions on the consumer's behalf, in the consumer's durable power of attorney for health care.

4g. Substitute Health Care Decision-Maker. An individual authorized to make decisions about a consumer's health care treatment decisions, pursuant to D.C. Official Code § 21-2210(a), when the consumer is incapacitated, and an attorney-in-fact was either not designated by the consumer or is unavailable.

4h. Qualified Practitioner. A board-eligible psychiatrist; a psychologist; an independent clinical social worker; an advance practice registered nurse; a registered nurse; a licensed professional counselor; an independent social worker; and an addiction counselor.

5. **Policy**.

5a. DMH strongly supports a consumer's right to create, or to choose not to create, advance directives. Any competent consumer who is 18 years of age or older may create any type of advance directive (living will, durable power of attorney, and/or advance instructions). Children and youth under 18 years of age are encouraged to participate in the advance health care planning process, but such documents are only valid with the consent and signature of a parent or legal guardian.

5b. Qualified practitioners shall incorporate the development of advance directives into the IRP/IPC planning process.

5c. D.C. Official Code § 7-628 and § 21-2209 prohibit conditioning the receipt of any kind of health care treatment, including mental health services upon either the completion of any advance directive or the modification of any existing advance directive.

5d. Advance directives (living will, durable power of attorney for health care, advance instructions) shall be adhered to by all mental health providers, pursuant to Chapter 1 of Title 22A, DCMR. A consumer's mental health treatment preferences (which may be documented in either a durable power of attorney for health care or advance instructions) shall be followed, except for good cause as documented in the consumer's clinical record, and shall never be overridden for the convenience of the Department or any of the consumer's mental health providers (See Section 9 below for description of good cause criteria).

5e. The existence of a consumer's advance directives shall not affect his/her right to make decisions about treatment when he or she is capable of making such decisions. A consumer is presumed capable of making health care decisions unless certified otherwise under D.C. Official Code § 21-2204.

6. **Procedures During the Admission/Enrollment Intake Process.** The core services agencies and Saint Elizabeths Hospital shall:

6a. **Ask** the consumer if he/she has already established advance directives (living will, durable power of attorney for health care, or advance instructions).

6b. **Document** the existence and location of any previously created and available advance directives in the consumer's clinical record, and **file** a copy in the record, if provided.

6c. **Inform** the consumer that he/she has the right to create, choose not to create, or modify existing advance directives.

6d. **Provide** the consumer with a copy of the DMH pamphlet on advance directives (Exhibit 4), and **inform** the consumer that further explanation will be provided when the consumer meets with a qualified practitioner.

6e. If the consumer is in acute distress, **delay** explanation of advanced directives until the consumer is more stable.

7. **Procedures During Development of a Consumer's Individual Recovery Plan (IRP) or Individual Plan of Care (IPC).** The qualified practitioners shall:

7a. **Review** the consumer's clinical record for advance directives, treatment preferences, or related notes; **ask** the consumer if he/she ever created any type of advance directive (living will, durable power of attorney for health care, or advance instructions); and if so, **request** a copy of the current documents from the consumer.

7b. **Incorporate** any previously created and available advance directives into the IRP/IPC planning process. **Immediately discuss** any mental health treatment preference that may be overridden and the reasons for the possible override (see Section 9 below for description of good cause criteria), and refer to the treating psychiatrist for further discussion if necessary.

7c. **Explain**, when clinically appropriate:

- what advance directives are used for;
- how the consumer can complete;
- that the creation of any type of advance directive is the consumer's choice;
- that the documents may be modified or revoked by the consumer (except when the consumer has been certified as incapacitated); and
- offer the consumer the opportunity to discuss/explore concerns.

7d. **Provide** a copy of the DMH pamphlet on advance directives if no advance directives are in the consumer's clinical record and/or cannot be obtained, or if the consumer wishes to revise.

7e. **Document** in the consumer's clinical record, the consumer's preference to create, modify, or not to create advance directives and the consumer's clinical condition. If questions arise as to the consumer's competency to complete or modify the advance directive forms, arrange for the consumer to be evaluated by the treating psychiatrist or psychologist.

7f. **Provide** forms to the consumer, and instruct parents or legal guardians of children or adolescents and legal guardians for adults to complete/assist in completing and sign the forms. **Advise** the consumer of the following:

- advance directives must be dated and signed and witnessed by two (2) adults, who shall not include the consumer, the consumer's health care provider(s), or any employee of the consumer's health care provider(s) or DMH, and

- at least one (1) of the witnesses shall not be related to the consumer by blood, marriage, or adoption, and shall not be entitled to any part of the consumer's estate.

7g. **Offer** assistance and **advise** consumers that they may contact the DMH Office of Consumer and Family Affairs at 202-673-4374 to obtain additional information, forms, assistance, and referrals to independent advocacy services; or they may ask a family member, friend, or member of the treatment team for assistance in completing forms.

7h. If the consumer creates new advance directives, **request** a copy, **ensure** the forms are signed and witnessed, and **place** the copy in the treatment plan section of the consumer's clinical record. **Clearly mark** any superseded advance directive as superseded, and include the date it was replaced. **Immediately discuss** any mental health treatment preference that may be overridden and the reasons for the possible override (see Section 9 below for description of good cause criteria). **Make note** to discuss and incorporate new or revised advance directives in IRP/IPC updates.

7i. **Encourage** the consumer to keep the original(s) of their advance directive(s) in a safe place, and **encourage** the consumer to provide copies of advance directives to the attorney-in-fact, family members, and personal representative as he/she deems appropriate.

7j. **Note** the existence of the advance directives on the first page of the IRP/IPC under the section titled "Consumer Participation in Plan", and **flag** the outside of the consumer's chart so the provider will know, at a glance, that a consumer has advance directives.

7k. **Provide** an advance directive card (Exhibit 5) for the consumer to complete, and to identify where the advance directive(s) are located.

8. **Procedures During Treatment.** Each treating clinician shall:

8a. **Review** and be knowledgeable about the consumer's advance directives (if any) throughout the treatment process.

8b. **Provide** the consumer, upon his/her request, the opportunity to make revisions to his/her advance directives (See also section 7g – 7k above).

8c. **Abide** by advance directives (living will, power of attorney, and/or advance instructions) as applicable whenever a consumer is certified as incapacitated.

8d. **Provide** the advance directive(s) to the consumer's other treating providers within the network as necessary in compliance with the privacy/consent requirements in DMH Policy 645.1, DMH Privacy Policies and Procedures.

8e. **Ensure** a copy of the advance directives are forwarded along with other key documents that follow a consumer whenever there is consumer movement (e.g., transfers/discharges/admissions to inpatient status or placement in residential treatment centers, community residential facilities, or other treatment programs).

9. **Good Cause for Overriding Mental Health Treatment Preferences.**

9a. DMH requires that all mental health service providers honor a consumer's treatment preferences with respect to mental health services and supports, as required by D.C. Official Code § 7-1231.06. However, a mental health service provider may disregard a consumer's mental health treatment preference(s) as described in an advance directive (advance instructions or durable power of attorney for health care) only for good cause, which must be documented in the consumer's clinical record.

9b. For purposes of this policy, the term "good cause" is defined to include those situations in which the consumer's preferred mental health treatment is:

(1) prohibited by either District or federal law;
(2) not within the generally accepted standard of care for mental health care treatment;
(3) not readily available;
(4) an emergency which poses a serious risk to the consumer's physical health; or
(5) medically contraindicated or prohibited by a court order.

9c. If a mental health service provider determines that "good cause" exists which would justify disregarding or overriding a consumer's mental health treatment preference(s), the mental health service provider shall:

(1) **document** the reasons for disregarding or overriding the consumer's mental health treatment preference(s) in the consumer's clinical record;

(2) **notify** the consumer and/or the consumer's family/guardian/substitute decision maker/attorney-in-fact, if applicable, of the reasons for disregarding or overriding the consumer's mental health treatment preference(s), and document the response;

(3) **advise** consumers that they may contact the DMH Office of Consumer and Family Affairs or independent advocacy services for assistance; and

(4) **cooperate** with the transfer or transition of the consumer to another mental health service provider, if requested.

9d. A consumer or his/her legal representative may file a grievance at any stage of the process if he/she disagrees with a mental health service provider's decision to overrule any mental health treatment preference.

10. **Community Residential Facilities (CRFs)**. Review and be knowledgeable about the consumer's advance directive(s) provided during placement and abide by applicable provisions.

11. **Training and Awareness**.

11a. DMH managers and providers of mental health services and supports shall ensure that all clinical staff and other appropriate staff in their organizations are aware of and familiar with this policy.

11b. The Office of Consumer and Family Affairs shall:

- **Ensure** that advance directive training is provided to DMH staff and to the staff of providers of mental health services and supports.
- **Ensure** that all DMH consumers receive information about advance directives and have the opportunity to receive training about their right to create advance directives.

12. **Inquiries**. The DMH Office of Consumer and Family Affairs (OCFA) may be contacted at 202-673-4374 to obtain additional information or assistance.

13. **Related References**.

DMH Consumer Rights and Protections Statement
Chapter 3, Title 22A, DMH Consumer Grievance Procedures
Chapter 22, Title 21, Health Care Decisions
DMH Policy 645.1, DMH Privacy Policies and Procedures

Martha B. Knisley
Director, DMH

8/31/04
Date

AUG 3 1 2004

Declaration of Living Will

I, _____ **(sometimes referred to as the "declarant")**, being of sound
(consumer's name)
mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two (2) physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

BY MY SIGNATURE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

I sign my name to this declaration of living will on_____, 20 _____.
(date)

at: _____
(address)

_____

_____

_____ _____
(consumer's signature) **(print consumer's name)**

WITNESSES

I am at least eighteen (18) years of age, and I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this declaration of living will in my presence, and that the person appears to be of sound mind and under no duress, fraud, or undue influence.

-Over-

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I am not the declarant (consumer), nor am I the health care provider or an employee of the health care provider from which the declarant receives services.

First Witness

Signature:_____ Date:_____

Print Name: _____

Home Address:_____

_____

_____

Second Witness

Signature: _____ Date: _____

Print Name: _____

Home Address:_____

_____

_____

AT LEAST 1 OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION:

I further declare that I am not related to the declarant by blood, marriage or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the declarant under a currently existing will or by operation of law.

Signature: _____ Date: _____

Print Name: _____

AUG 3 1 2004

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Information About This Document

This is an important legal document. Before signing this document, it is vital for you to know and understand these facts:

- This document gives the person you name as your attorney-in-fact the power to make health care decisions for you if you cannot make the decisions for yourself.
- After you have signed this document, you have the right to make health care decisions for yourself if you are mentally competent to do so. In addition, after you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision.
- You may state in this document any type of treatment that you do not desire and any that you want to make sure you receive.
- You have the right to take away the authority of your attorney-in-fact, unless you have been deemed incapacitated, by notifying your attorney-in-fact or health care provider either orally or in writing. Should you revoke the authority of your attorney-in-fact, it is advisable to revoke in writing and to place copies of the revocation wherever this document is located.
- If there is anything in this document that you do not understand, you should ask a social worker, lawyer, or other person to explain it to you.
- You should keep a copy of this document after you have signed it. Give a copy to the person you name as your attorney-in-fact. If you are in a health care facility or receiving services from a health care provider, a copy of this document should be included in your clinical record.

Note: Any written form meeting the requirements of D.C. Code § 21-2205 may be used to create a durable power of attorney for health care. **This form is a sample form of a durable power of attorney for health care**. District of Columbia law does not preclude the use of alternative language in a durable power of attorney for health care.

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DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I,_____ (sometimes referred to as the "principal"),
(consumer's name)

hereby appoint:_____ _____
(name)

_____
(home address)

_____

_____

_____ _____
(home telephone number) (work telephone number)

as my attorney-in-fact to make health care decisions for me if I become unable to make my own health care decisions. This gives my attorney-in-fact the power to grant, refuse, or withdraw consent on my behalf for any health care service, treatment or procedure. My attorney-in-fact also has the authority to talk to health care personnel, get information and sign forms necessary to carry out these decisions.

If the person named as my attorney-in-fact is not available or is unable to act as my attorney-in-fact, I appoint the following person to serve in the order listed below:

1. _____
(name)

_____
(home address)

_____

_____

_____ _____
(home telephone number) (work telephone number)

2. _____
(name)

_____
(home address)

_____

_____

_____ _____
(home telephone number) (work telephone number)

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With this document, I intend to create a durable power of attorney for health care, which shall take effect if I become incapable of making my own health care decisions and shall continue during that incapacity.

My attorney-in-fact shall make health care decisions as I direct below or as I make known to my attorney-in-fact in some other way.

(a) STATEMENT OF DIRECTIVES CONCERNING LIFE-PROLONGING CARE, TREATMENT, SERVICES, AND PROCEDURES:_____

_____

_____

_____ _____.
(consumer's initials)

(b) SPECIAL PROVISIONS AND LIMITATIONS: _____

_____

_____

_____ _____.
(consumer's initials)

(c) OTHER CARE, TREATMENT, SERVICES AND PROCEDURES INCLUDING MENTAL HEALTH TREATMENT:_____

_____

_____ _____.
(consumer's initials)

BY MY SIGNATURE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

I sign my name to this durable power of attorney for health care on_____, 20 _____.
(date)

at: _____
(address)

_____

_____

_____ _____
(consumer's signature) **(print consumer's name)**

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WITNESSES

I am at least eighteen (18) years of age, and I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this durable power of attorney for health care in my presence, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not the principal (consumer), the person appointed as the attorney-in-fact by this document, nor am I the health care provider or an employee of the health care provider from which the principal receives services.

First Witness

Signature:_____ Date:_____

Print Name: _____

Home Address:_____

_____

_____

Second Witness

Signature: _____ Date:_____

Print Name: _____

Home Address:_____

_____

_____

AT LEAST 1 OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION:

I further declare that I am not related to the principal by blood, marriage or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal under a currently existing will or by operation of law.

Signature: _____ Date: ____ _____

Print Name: _____

AUG 3 1 2004

DECLARATION OF ADVANCE INSTRUCTIONS
(for mental health treatment)

Part I
Statement of Intent

I, **(consumer's name)** _____ **(sometimes referred to as the "principal")**, being of sound mind, voluntarily create these advance instructions for mental health treatment to assure that my choices will be carried out if I am unable to make my own decisions.

By this document, I intend to create a declaration of advance instructions for mental health treatment as authorized by District of Columbia law, to indicate my wishes regarding mental health treatment. To the extent, if any, that this document is not valid under District of Columbia law, it is my desire that it be considered a statement of my wishes and that it be given the greatest possible legal weight and respect. I understand that this directive will only be used when I cannot make my own mental health treatment decisions.

Even if I left blanks on the form or did not complete certain sections, I want all completed sections to be followed. If I have not expressed a choice, then whoever is appointed as my substitute decision maker should make the decision that he or she thinks is the decision I would make if I were able to do so.

It is my intention that each part of my advance instructions for mental health treatment stand alone. If some parts are invalid under District of Columbia law or ineffective, I desire that all other parts be followed, by whoever is appointed as my substitute decision maker.

I intend this declaration of advance instructions for mental health treatment take precedence over any and all living will and/or durable power of attorney for health care documents and/or other advance directives I have previously executed that addresses mental health treatment, to the extent that they are inconsistent with this document.

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Part II.

Statement of My Instructions Regarding My Mental Health Treatment.

In this part, you state how you wish to be treated (such as which hospital you wish to be taken to, which medications you prefer) if you are unable to express your own wishes.

If you do not want the paragraph to apply to you, leave the line blank.

1. Choice of Hospitals.

A. In the event I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals:

Name	Reason (optional)

B. I do ***not*** wish to go to the following hospitals:

Name	Reason (optional)

2. Instructions Regarding Emergency Interventions.

If, during an admission or commitment to a mental health treatment facility, it is determined that I am behaving in a way that requires emergency treatment, my wishes regarding which form of emergency treatment I receive are as follows:

_____

_____

_____

3. Instructions Regarding Treating Doctors.

Complete if you have a preference.

A. My choice of doctors are:

Name	Reason (optional)	Telephone #
1.		
2.		

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4. Instructions Regarding Medications.

I am taking the following medications as of _____ /_____ /_____, List medication names and dosages: (Date)

_____ _____

_____ _____

_____ _____

I find the administration of the following medications to be helpful (*list any special circumstances):* **It is recommended that you obtain advice or resources in completing this section.**

_____

_____

I prefer not to receive the following medications *(list reasons, if possible):*

_____

_____

5. Instructions Regarding Pharmacy. The name, location, and phone number of my pharmacy is:

_____

_____

6. Instructions Regarding Approaches That Help Me When I'm Having a Hard Time.

If I am having a hard time, the following approaches have been helpful in the past:

[ ] Voluntary time out in my room	[ ] Listening to music	[ ] Exercising
[ ] Voluntary time out in quiet room	[ ] Calling my therapist	[ ] Reading
[ ] Talking to my psychiatrist	[ ] Punching a pillow	[ ] Going for a walk
[ ] Talking with a peer	[ ] Pacing the floor	[ ] Pounding clay
[ ] Being with certain people/not being with certain people (specify):	[ ] Talking with staff	[ ] Calling a friend
[ ] Deep breathing exercises	[ ] Writing in a journal	[ ] Adjusting diet
[ ] Having cool water available	[ ] Having my hand held	[ ] Lying down
[ ] Taking a shower/bath	[ ] Medication as needed	[ ] Sitting near staff
[ ] Watching TV	[ ]Other (specify)	

[ ] Other _____

_____

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7. Instructions Regarding Actions That Are *Not* Helpful.

In the past, I have found that the following actions make me feel worse:

[ ] Exposing one's situation to others	[ ] Seclusion	[ ] Restraints
[ ] Being touched	[ ] Lying down	[ ] Talking with peer(s)
[ ] Sitting near staff	[ ] Being held	[ ] Loud talking
[ ] Writing in journal	[ ] Loud noises	[ ] Crowds/crowding
[ ] Being compared to others	[ ] Other	

[ ] Other _____

_____

8. Special Instructions Regarding Touch/Body Space Considerations.

[ ] I do not want to be touched

[ ] I want to be asked permission before being touched

[ ] I want to be told reasons why I am being touched

[ ] I want special attention to be given to allowing me extra personal body space

[ ] Other _____

_____

9. Instructions Regarding Other Treatments *(counseling, socialization etc.).*

_____

_____

_____

Part III.
Appointment of Substitute Decision Maker.

In the event that a court decides to appoint a guardian or substitute decision maker to make decisions regarding my mental health treatment, I desire that the following person be appointed:

Name: _____ Relationship: _____

Address: _____

_____

_____ Telephone # _____

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Part IV.
Instructions for Notification of Others, Visitors, and Custody of My Children.

1. Who Should Be Notified Immediately of My Admission to a Hospital.

I want staff to tell the following people that I have been admitted to a hospital when I am unable to tell them myself:

Name	Relationship	Telephone #	Address	May Visit	
				Yes	No

2. Who Should Be Prohibited from Visiting Me.

I do not wish the following people to visit me while I am in the hospital:

Name	Relationship

3. Instructions for Care & Temporary Custody of My Children.

In the event that I am unable to care for my child(ren), I want the following person to care for and have temporary custody of my child(ren):

	Name	Relationship	Telephone #	Address
1st Choice				
2nd Choice				
3rd Choice				

4. Instructions for Care and Temporary Custody of the Following:

	Name	Relationship	Telephone#	Address
Pets				
Financial Affairs				
Other Important Matters				

-Over-

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Part VI.
Signature of Principal (Consumer) and Witnesses.

BY MY SIGNATURE I INDICATE THAT I, OR MY LEGAL GUARDIAN IF I AM UNDER THE AGE OF 18, UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

I sign my name to this declaration of advance instructions for mental health on:_____, 20 _____
(date)

at: _____
(address)

_____

_____

_____ _____
(consumer's signature) (print consumer's name)

_____ _____
(legal guardian's signature) (print legal guardian's name)

WITNESSES

I am at least eighteen (18) years of age, I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this declaration of advance instructions for mental health treatment in my presence, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not the principal (consumer), nor am I the health care provider or an employee of the health care provider from which the principal receives services.

First Witness

Signature: _____

Print Name: _____

Home Address:_____

_____

Date: _____

Second Witness

Signature:_____

Print Name: _____

Home Address:_____

_____

Date:_____

AT LEAST 1 OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION:

I further declare that I am not related to the principal by blood, marriage or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal under a currently existing will or by operation of law.

Signature: _____ Date: _____

Print Name: _____

Any disclosures or notifications authorized or made pursuant to this document will comply with any applicable provisions of HIPAA and the MHIA. Please refer to DMH Policy 645.1 (DMH Privacy Policies and Procedures) or other privacy resources if you have any questions.

This form itself contains confidential information that should not be disclosed except as authorized or required by law.

AUG 3 1 2004

MAKING DECISIONS ABOUT YOUR HEALTH CARE

INFORMATION FOR CONSUMERS

This pamphlet tells you how you can make decisions about your health care.

District of Columbia
Department of Mental Health
DMH

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MAKING DECISIONS ABOUT YOUR HEALTH CARE INFORMATION FOR CONSUMERS

This information is being given to you in compliance with a federal law called the Patient Self Determination Act. This law is designed, along with District of Columbia law, to protect your rights to make decisions about your own health care, including the right to accept or refuse life-sustaining medical treatment, and mental health treatment.

Your care will be provided whether or not you have written any of the documents discussed in this booklet.

AS AN ADULT, YOU HAVE THESE RIGHTS:

- You have the right to choose what medical treatment you want in the event of a terminal medical condition (living will).
- You have the right to appoint someone to make your health care treatment decisions for you if you cannot make those decisions yourself (durable power of attorney for health care).
- You also have the right to state the mental health treatment decisions that you prefer to be followed whenever you cannot make those decisions for yourself (advance instructions).
- You can make your decisions about your health care known by telling your family, close friends, doctor, nurse, or others, or by putting your directions in writing.
- You can change your mind at any time.

CHILDEN AND YOUTH under 18 years of age are encouraged to help in the advanced health care planning process, but the documents are only valid if a parent or legal guardian sign them.

WHY SHOULD I BE INVOLVED IN DECISIONS ABOUT MY HEALTH CARE TREATMENT?

Your health care affects **you** most of all, so **you** should be involved in any decisions about **your** treatment.

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HOW CAN I BE INVOLVED IN DECISIONS ABOUT MY HEALTH CARE?

- Talk with your family, close friends, doctor, nurse, social worker, or community support worker/case manager about the decisions you want to make.
- Ask questions and let those involved in your care know what your wishes are.
- Talk to them about what you want now. But, also talk to them about what you would want in the future if you cannot make your own decisions.
- You can protect your rights by writing down your wishes and having two witnesses sign the document. Such a document is called an Advance Directive.

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a document in which you say what you want done if you cannot make your own health care treatment decisions. There are three (3) kinds of advance directives.

- In a living will, you say what kind of treatment you do or do not want if you are unable to make your own health care treatment decisions. A living will applies only when you are in a terminal condition.

- In a durable power of attorney for health care, you appoint a person to make decisions for you about your health care treatment, including mental health care, when you are unable to make your own decisions.

- In advance instructions for mental health care, you state your wishes regarding mental health treatment, for when you are unable to make your own decisions.

WHO DECIDES THAT I AM UNABLE TO MAKE HEALTH CARE TREATMENT DECISIONS?

By law, you are assumed to be able to make health care treatment decisions unless two (2) doctors (one must be a psychiatrist) agree that you are not able to understand treatment decisions.

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WHO WILL MAKE TREATMENT DECISIONS FOR ME?

You may appoint a specific person to make health care treatment decisions for you in a durable power of attorney for health care.

If you have not appointed someone to make health care treatment decisions for you when you are unable to do so, District law authorizes a substitute decision maker to make health care decisions for you in the order of priority set forth below. Substitute decision makers include:

(1) a court-appointed guardian or conservator;
(2) your spouse or domestic partner;
(3) your adult child;
(4) your parent;
(5) an adult sibling;
(5A) your religious superior (if you are a member of a religious order or a diocesan priest);
(5B) a close friend; or
(6) your nearest living relative.

District law requires that all substitute decision makers follow your wishes to the extent known.

Even if you decide not to make an advance directive, you still **should** discuss your wishes about health care treatment with your family and friends so they will be aware of your wishes.

WHAT SHOULD I SAY IN MY ADVANCE DIRECTIVE(S)?

You can say anything you want about your health care treatment wishes. One way to get started writing an advance directive is to think about the following questions. Your answers to these questions should be included in your advance directive(s).

For example, these are some of the things you might want to include in a living will:

- Do you want treatment to try to restart your heartbeat or breathing (resuscitation)?
- Do you want to be put on a breathing machine (ventilator or respirator) if you can't breathe on your own?
- Do you want to be fed by tubes (receive artificial nutrition and hydration) if you can't eat or drink on your own?

- Do you want to be kept as comfortable and free of pain as possible, even if such care prolongs your dying or shortens your life?

Things you might want to consider in your advance instructions for mental health treatment:

- Do you prefer certain medications?
- What are your treatment preferences during an emergency or crisis?
- Who should be contacted to handle your personal business and take care of your children and belongings?
- Who should, or should not, be contacted in the event of an emergency?

Ask yourself the following questions when creating a durable power of attorney for health care:

- Who is the person who knows you best and will follow what you say?
- Who is the person you trust to make decisions in your best interest?

MUST I HAVE AN ADVANCE DIRECTIVE?

No, but it is a good idea to have so that your doctor, your family and others know what you want if you ever become unable to make health care treatment decisions for yourself.

HOW DO I WRITE AN ADVANCE DIRECTIVE?

Writing an advance directive takes serious thought. You can ask your doctor, nurse, social worker, or community support worker/case manager for a form(s), and someone will discuss this with you, upon request. You can also talk to anyone you trust about your advance directive and/or health care treatment wishes.

WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE(S)?

You should give a copy to the person you appoint to make treatment decisions for you, your doctor, your family, and anyone else who might be involved in making decisions about your treatment. You should keep the original(s) in a safe place.

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HOW CAN I MAKE SURE MY ADVANCE DIRECTIVES ARE LEGAL?

DMH has developed forms for a living will, durable power of attorney for health care, and advance instructions for mental health care that comply with federal and District law. You may obtain a copy of those forms from your mental health provider or the Office of Consumer and Family Affairs at (202) 673-4374.

You may also ask a lawyer help you write your advance directive(s) or check one you have written.

WHAT IF I WANT TO CHANGE MY ADVANCE DIRECTIVE(S)?

You can change or cancel your advance directive(s) at any time. You can write new advance directive(s), destroy the old ones, or tell those involved in your care that you have changed your mind. It is very important to let anyone involved in your health care, including mental health professionals, know that your wishes have changed.

If you feel that your rights have been limited, violated, or if you are dissatisfied with mental health services or supports provided, you may contact your mental health provider or call or visit the Office of Consumer and Family Affairs (OCFA) at:

(202) 673-4374
Location:
64 New York Avenue, NE
4th Floor

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Government of the District of Columbia

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Advance Directive(s) Card

I, _____ **have the following Advance Directive(s):**

_____

_____

In case of an emergency, contact the following Key Contact Person:

Key Contact Person: _____

Address: _____

Phone: _____

Advance Directive(s) Locations:

Location	Initial	Date

If Found Return To: _____