Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Psychiatric Advance Directives: A second look

Patricia M. Siebert
Minnesota Disability Law Center

Marie Verna
Rutgers University Behavioral Health Care
Behavioral Research and Training Institute
Feature Topics

- Recommendations for assisting individuals in developing their own PAD
  - Best practices for disseminating PADs
  - Raising awareness
- Ensuring PADs are accessible/inform care decisions
- Roles and approaches for responding to PADs
  - 1:1 and as agency policy/accountability
- Understanding the limitations of PADs
  - Legal implications
  - Clinical implications
Today’s approach:

Q&A – Interview style

• Answering questions that remained from the presentation provided in October
• Clarifying points that were brought up by the audience members
• Leaving time for questions that you may submit throughout the call
Your Questions

Are PADs the same across all states?

Are the rules the same or different?

Can I use the same PAD if I move to a new state?
Considerations State-to-State

Basics Components
- Presumption of capacity
- Written; instructions and/or named/specified agent
- Witnessed/notarized
- Language directing providers to act in good faith w/in community standards; immunity for those who do;
- A revocation process

Common Differences
- PAD law or HCD law
- Specific expiration limits?
- Revocation variables:
  - How and when?
- State registry?
- Implications if there is a guardian appointed or conservatorship?
- Moving from state to state?
- Updating a PAD?
What’s my job?

When is the best time to engage an individual in creating an advance directive?

How much help or support can I as a clinician or supporter provide?
Consider your role and service array

• **Best time? When someone is doing well!**
  - Make sure people know about PADs
  - Explain the benefits of a PAD
  - Avoid ‘forcing’ the creation of a PAD
  - Incorporate with working a WRAP®

• **Providers are allowed to help**
  - Think through medication issues with the person
  - Think beyond medical issues (care of children, home, pets, plants)
  - Think about relationships and who needs info
  - Discuss limitations (distance, insurance, money)
  - Providers should not serve as named agents
Clarifying Question

What is the difference between informed consent and informed decision making?

Aren’t they really the same thing?
Clarification

Providers tend to approach care in terms of what is in someone’s best interest but personal decision making is more complex.

**Informed consent** implies that the person will consent to treatment/services being proposed, which are based on medical ‘facts’.

**Informed decision-making** acknowledges that there are considerations other than medical considerations involved in what a person chooses; given spiritual, cultural and moral beliefs and preferences.
Popcorn Chat

• Consider your own personal life and circumstances. What is one thing YOU would want to include in a personal psychiatric advance directive?

• What item or consideration you would want available should you need your advance directive activated?

• Insert the item in the chat box and press enter.
What should be included in a PAD? I don’t know what’s allowed or not allowed.

Is it better to put in what you want or what you don’t want?
Address both what one wants and does not want

• Discuss “reasonableness”
  • Requests need to be available, consistent with standards of care, legal and ethical
• What initiates the activation of the PAD?
• What (if any) medications are okay?
  • Criteria for new medications that may be proposed (“I give permission to try this med but if I have these side effects please wean me off.”)
• Allow or disallow ECT – under what conditions?
• Important history to share:
  • Past trauma  • Bad reactions  • Medical conditions
• Behavioral techniques which help calm
• People to involve or not involve; HIPAA releases
• Providers to be involved in care
Questions about PAD “agents” and staff roles

Are there any rules about who can and cannot serve as your PAD agent?

Are Peer Specialists or other professionals able to serve as an agent?

Does a PAD with an agent have more weight than one without one?
Considerations

As a rule, a PAD with a trusted agent is stronger

- Due to potential conflicts of interest, providers should not serve as named agents in a person’s PAD
- Someone in the person’s corner who is a voice for them
- Someone who can have access to medical info and talk with care providers
- Someone who can roll with the punches, adjusting to different circumstances
- Someone who can deal with bureaucracy, such as appealing a negative decision by insurer
What About Specific Rules

Are PADs only applicable to psychiatric admissions?
Will medical needs override your PAD?
What healthcare providers are required to ask about and follow PADs?
Does this apply to outpatient care or only hospitals/inpatient?
Considering the Rules

- **PADs are general specific to BH treatment**
  - A person should have both PAD and Health Care Directive (HCD), if needed (complex health needs)
  - Consider having the same agent
  - Make sure both agents have both documents
- ‘Override’ is a misnomer — physician judgment based on medical standards that prevents following PAD instructions is not the same as invalidating the PAD
- All providers should be asking about a PAD/HCD, not just in inpatient settings, and must put a copy in the medical records if the person asks that to be done
Revocation or Disallowed?

Are individuals who are under a court order or conservatorship able to develop/use a PAD?

Who can revoke a PAD? When and how can I revoke it? Is there a procedure that must or should be followed?

Conservatorship is a legal concept where a guardian and protector is appointed by a judge to manage the financial affairs and/or daily life of another due to physical or mental limitations.
Exploring revocation or disallowed PADs

This is a complicated (and State-specific) question:

• Understand your terms and use them correctly (conserved vs guardianship vs court-ordered)
• Date and conditions under which the PAD was created can be factors
• Even not legally binding due to circumstances, it is always better to let your wishes and preferences be known
• Presumption of competency for a civilly committed person
• Court orders (involuntary medication, restraining orders, etc.) might impact PAD and choices
Uniqueness of PADs?

How personalized can a PAD be? Can PADs be altered and modified to the individual's language and literacy?

Would the PAD be accepted in the courts or medical/psychiatric settings if it is altered to the individuals liking?
Considerations for personalization

PADs are supposed to say what the person prefers

- Be clear. Will the reader understand the intent?
- PADs, while legal documents, are “do it yourself” too
- Use your way of speaking and language of choice
- Add sections that may not be included. Want trauma specific care? Ask for it. If form not include this, add it
- If the PAD meets basic legal requirements, a court and provider should acknowledge it as your wishes.

- **PADs may be rejected when:** Only one witness and the statute calls for two; not in legal form; if you have previously been found incompetent
What are organizations doing to promote acceptance of PADs?

How do these organizations advocate for PADs to be recognized or taken more seriously in my state?

Are there things advocacy organizations or peers can do to make this happen?

- National Resource Center on Psychiatric Advance Directives
- The Bazelon Center for Mental Health Law
- Mental Health America
- NAMI
Considerations for advocacy

PADs help service and treatment providers!

• Communicates person’s best idea of what works for them
• Identifies previous problems/successes with various medications or treatment interventions
• Great way to get to know a person better
• Helps the provider see past assumptions about capacity and focus on wishes and preferences
• Clarifies permissions to release medical information
• Helps organize arrangements for children, pets, finances during a time of crisis
• It’s the law -- both state and federal
Advocacy: after the law is passed the next steps are training and enforcement!

- Research existing examples of PAD forms when developing your state specific form
- Your legal associations, P&As, or volunteer attorneys may be willing to help
- Use the process for coalition building - meet with advocates, doctors, providers and leadership
- Have ‘PAD-ins’ where people can work on their PADs.
- YouTube videos: “Here’s how my PAD worked for me”
PAD Resources

• Links
  • http://www.mentalhealthamerica.net/psychiatric-advance-directives-taking-charge-your-care
  • http://www.bazelon.org/Where-We-Stand/Self-Determination/Advance-Directives.aspx
  • http://www.nrc-pad.org/
  • www.ndrn.org

• Reports/Articles

• Templates
  • http://pad.duhs.duke.edu/templates.html
Discussion and final comments
Recovery to Practice

Through education, training, and resources the Recovery to Practice (RTP) program supports the expansion and integration of recovery-oriented behavioral health care delivered in multiple service settings.
Discipline-based curricula is available on the RTP website.
SAMHSA’s 10 Principles and 4 Dimensions of Recovery in Behavioral Health

- Home
- Health
- Community
- Purpose

- Respect
- Strengths / Responsibility
- Addresses Trauma
- Culture

- Person-Driven
- Many Pathways
- Holistic
- Peer Support

- Relational
RTP Training and Technical Assistance

Free Webinars
Click Here!

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Great Newsletter
RTP Email Sign Up
Click Here!

Helpful Website
http://www.samhsa.gov/recovery-to-practice

Click the link for continuing ed hours from NAADAC or to download a certificate.