

A Second Look: Psychiatric Advance Directives

Welcome, everyone. This is Melody Riefer; I'm going to be your moderator for today's webinar. We're really glad that you've joined us today.

Before we begin, just a couple of housekeeping notes. You should be mindful that this is Part 2 of a series of two; and if you were not able to join us for the first webinar, which aired in October, it is available for download or to listen to at the Recovery to Practice website. We would encourage you to go there and check out that webinar. We will be providing a link to that site at the end of today's presentation.

Also, we've had some technical difficulty today with the closed captioning functionality. It does appear to be working fine right now. However, if the closed captioning goes down and there are gaps created because of that, please let us know if you need a copy of the completed scripts; and we will send those to you upon request.

Our last couple of slides of today's time together will give you information about the Recovery department's project and how to sign up for our newsletter and how to visit our page on SAMHSA's website. We want you to know that this webinar has been preapproved for continuing education hours from NAADAC, the Association for Addiction Professionals. To qualify for these continuing education hours, which are accepted by some other disciplines, you must attend the full webinar; complete a complete a brief quiz and the webinar evaluation. There is going to be a link at the end of the webinar where you can click and complete these tasks so that you can get that credit. Please plan to stay through to the end if you're able.

At the bottom of the screen that you're viewing right now, you'll see a "Download Materials Here" box, where you can access our presenters' complete bios, as well as a PDF of the presentation slides; a certificate of participation; and any other available materials that we've included.

There's also a document titled, "Five in Five," which includes additional resources with links and brief descriptions for you to view.

Finally, if you are a registered attendee, you are going to receive an e-mail to the link of the archived recording. This link will be available soon on SAMHSA's Recover to Practice website.

Again, thank you for joining us; and we will move forward with the content of today's call.

Psychiatric advance directives are important, and we're really excited to bring you some additional information that really has been created based on the energy and the advocacy that happened during the first webinar. We didn't intend to do a series, but the audience participation and response to the first webinar was a cue to us to do more about this topic. Our subject matter experts bring both legal and direct service experience to this topic.

Patricia Siebert is an attorney with the Minnesota Disability Law Center and has been supporting the use of and teaching about psychiatric advance directives since Minnesota passed legislation supporting the use of these documents to improve the participation and rights of people in behavioral health care.

Marie Verna, with Rutgers University Behavioral Health Center's Research and Training Institute, has been training people to use psychiatric advance directives through various advocacy organizations, including Mental Health America. She has also had personal experience with creating and using the psychiatric advance directives in her own services to ensure her care matches her preferences.

Our objective today is to address the many questions posed by the audience attending our first webinar addressing psychiatric advance directives. Please note, however, that we have built in time at the end of this webinar if additional questions come up; and we will attempt to get to as many of those as we can.

We'll be looking at various aspects of psychiatric advance directives, including the items that you see bulleted on the screen: recommendations for assisting individuals in developing their own psychiatric advance directives; ensuring that the forms are accessible and the process is accessible – that people understand informed care decisions and how they can play a role in that; and we want to pay close attention to the role of providers in relationships to psychiatric advance directives. People aren't born, nor can they intuit, that these options exist. So our roles as providers really are focusing on education, letting people know that psychiatric advance directives exist and wrapping their heads around how they can use psychiatric advance directives.

Then the other piece of that is as clinicians, or as providers, how do we respond when we are tasked with incorporating someone's psychiatric advance directive into the care that we're providing?

Today's approach is a little bit different than what we've done in the past. We're going to conduct the webinar in an interview style. So I'm going to pretend that I'm sitting on some fancy NPR radio station with fantastic subject matter experts and posing questions to them and waiting to be illuminated. In fact, that's what's going to happen because our experts carry such depth of understanding and experience with this process.

So we'll just go ahead and begin the interview process.

Patricia and Marie, thank you for being here. I want to begin with our first couple of questions. These have to do with trying to understand the national or the federal level of influence for psychiatric advance directives compared to if the rules or legislation varies from state to state.

Patricia, I'm wondering, could you help us in addressing these questions?

Sure, and good afternoon, everyone. Thank you for joining us. I can just give you kind of an overview of the basic components of a psychiatric directive. In some ways, if you think about a will, they are really very similar. The person is drafting the document. There is a presumption of law, pretty much in every state, that a person has the capacity to draft a psychiatric directive. The directive is written, so it has instructions; and, again, some of this varies from state to state. Some states only have agents; some states have instructions and agents. So you would need to really check with your state; and a good way to really do that is through your protection and advocacy program, which is what I am a part of in Minnesota.

Directives usually have to be witnessed or notarized some way to document that the person signing the directive is the person who made the directive. They all have some sort of standards or designation of when a directive is activated; they all have a revocation process; and they all have some sort of language creating safeguards or immunity for agents and providers who act in good faith.

There are some differences from state to state too to be aware of. Some states don't have a separate psychiatric advance directive law, so a psychiatric directive would be within the state's existing health care directive law. I think there are somewhere around 15 or 20 states that have specific PAD directive statutes. Sometimes states have specific expiration limits or other limits. I think Pennsylvania has a two-year limit on a psychiatric directive, which kind of raises an interesting issue compared to other health care directives.

When you can revoke a directive can change from state to state. Some states say if you're in the hospital, you can't. A lot of states say if you're currently not capable of revoking a directive, and the directive has activated, you can't; it's locked in. So there are those kinds of differences as well. Some differences about what happens if a guardian is appointed and you have a directive, and then certainly when you move from state to state. Most statutes have provisions about that, but I think the general rule is the idea behind a directive is that it expresses your wishes; and so if there's a valid directive from another state that expresses your wishes, there are lots of good reasons to honor that.

I know we're going to be going into some aspects of those points a little deeper with some follow-up questions, but I wanted to check in with Marie.

Thank you for being on the call, Marie. As I understand it, you have some information to share about compromise on revocations.

Yeah, thank you, Melody; and thank you, everyone on the line. It's very gratifying that people want to learn about this.

I was involved when I worked at the Mental Health Association of New Jersey. We were the lead on the effort in Jersey to pass PAD legislation. One of the biggest questions that we got all the time from everybody -- from families, consumers, from providers, from psychiatrists -- was, well, what if the person wants to change it in crisis?

So in our language, and I believe in most state's language, it's when could it be revoked? Here in Jersey, we actively talked with psychiatrists about their concerns; and most of it has to do with liability -- that under the person's care, *they* may do something that was dangerous for the person and not within standard care.

So our Office of Legislative Services let us know that the psychiatrists were really not interested in the current version of our bill until we accommodated that concern. So our compromise with the psychiatrists was language in the bill that says that it can't be revoked when someone is in a psychiatric hospital. We tried to specify that if a person is in a psychiatric hospital and the psychiatrist and the screeners are coming to the conclusion that this person is able to be committed, then they wouldn't be able to revoke at that point. I just wanted to give that as an example of how that's something that might change; that was specifically brought to our attention by our legislative -- the office that actually writes all the laws.

That's helpful to have that example, and I think that it underscores the reason why making sure you know what your state's legislation is or approved roles are regarding psychiatric advance directives. As we go through the rest of the webinar, the context is of course we'll try to speak as generally as possible; but you'll want to check out the technicalities for your state through your protection and advocacy organizations or through other resources. Your state department's behavioral health may be able to assist, as well as other attorneys.

I mentioned the importance of psychiatric advance directives and the role of the professional, of the provider. This is really true across disciplines. So whether someone is a psychiatrist and focusing on managing medication or whether someone is providing peer services in a peer run organization, we may have to respond to psychiatric advance directives.

What's my job then? When is the best time to engage an individual in creating an advance directive? Am I allowed to even help them do this, Patricia?

I think a good provider who is working with someone is really essential to answering their questions and helping them think about what they want to put in their advance directive. So when is the best time? Well, of course the best time is when somebody is doing well; but that can also include situations where somebody has, say, been in the hospital and they're saying to their therapist or doctor, "I don't want to go through that again," or, "The next time I'm in the hospital, I want this to happen instead of that." Those are really good times to say here's a vehicle for you to put down some of those wishes and instructions and have other people honor them. So I think there are some opportunities that are presented when people have been through treatment or they're talking to you about what they want to have happen.

I think another good time is when somebody is looking at wellness recovery or other kinds of crisis planning when they're not in crisis. So I think there are a lot of opportunities that can be presented, and I think providers can be really helpful in helping people talk about their condition, talking about treatments, talking about alternatives. Maybe if you're talking to your psychiatrist about that time you were on that medication and you had those side effects, or now I'm on one that's working really well but how do I want to write about that in my directive? So I think there are some ways in which providers can really help people understand the parameters of what they want to articulate in their directives.

I think having forms helps as well because it gives people some ideas about the variety of things that can be included in a directive. So maybe there are issues with medication, and I'm here to talk to you about your experiences with medication; but one of the things that really has made you anxious in the past is worrying about what's going to happen with your children. Here's how a directive can maybe help with that. I know that your Uncle Joe is really kind of overwhelming for you and that you don't want him involved in your care. That's something you can include. So I think there are a number of ways and opportunities for providers.

I know Marie has done a lot of trainings on this too and so, I think, has a lot of observations as well.

Yeah, I get this a lot too; and I feel like as a provider of any kind, if you're observing tension or disappointment between a person and his or her family or friends or what we call supporters, or tension with the treatment team, I think that's a good time to check whether or not that person is thinking about things -- that they really want to prevent certain things from happening again. So it's really thinking about when you know that you're escalating things that have happened that you don't want them to happen again -- it's very unfortunate that they did, and it was probably traumatic. So thinking in terms of early intervention is the way I feel -- that's how it helps me, where I look at things that were hard in a crisis or even when I was just decompensating.

I'd like people to remember we call them psychiatric advance directives, meaning this is all in advance of the worst. So that's the way I try to think about my psychiatric advance directives. So when I see a consumer -- there's tension and the family doesn't believe that they'll do what's in the directive, or the family is frustrated, or the doctor is frustrated, or you yourself are frustrated with yourself -- help a consumer in a gentle way so that you're not retraumatizing, but help them think about what was distressing. Help them think about it really specific terms.

The example that I give is my fourth hospitalization, they would not let my sisters come through some door; I don't even remember what door. It was the worst thing that could have happened to me at that point. My sisters were my life blood, and that was my only hospitalization where I needed to be restrained or put in seclusion. And to this day, I know that that could have been prevented; and now it's in my psychiatric advance directive. If I'm sane, I want to be with my sisters; and put me someplace where I'm allowed to be with my sisters.

That's a great example of clarifying what it is that you do want and what it is that you don't want.

Can I just mention one other thing? I think providers are really good on kind of a technical level to talk about things like I'm your community doctor, but I don't have privileges in the hospital; so I won't be able to help you when you're in the hospital. Your clinic isn't under this insurance plan; or here in Minnesota, you really don't have what hospital you're going to end up at if you need to be hospitalized. So pointing out some of those considerations for people, I think is really a helpful role for providers too.

That's a really important point. If the provider has the expertise around navigating the ins and outs of the system, then sharing that and how the person can -- I guess that comes to reasonableness, which I think is something we're going to talk about in a few minutes -- but knowing that there are some frameworks in which to work.

One of the things that always comes up is when people are talking about advance directives and forms and signing things, they're like, "How do I know what I'm signing? I hear the language about giving informed consent, but I'm not sure what that is."

On our previous call, Pat, you mentioned specifically claiming it as informed decision-making. Aren't they really the same thing, or how can you help me understand that better?

Well, I think if you're informed decision-making leads to consent, they're pretty much the same thing; but I think the presumption shouldn't necessarily be that the decision you make is going to be to consent. So informed decision-making is really kind of a more objective way of looking at it.

The idea of informed consent goes back to the notion that even medical professionals can't invade somebody else's body without their consent. So that's really where it comes from, and how do you get that consent? You talk about the necessity of a procedure or a treatment, the pros and the cons and consequences if you don't get it, and so on. And some people might say no; and they might say no because they have other considerations, something besides the bare medical considerations. It might have something to do with their own personal belief system, their religious belief system, where they are at the stage in their life.

So I think one of the roles of providers is to really provide the basic information that will help the person weigh the pros and cons and make a decision that is basically based on not just medical facts, but that person's individual beliefs and choices. So it's really about one's own choices.

That's helpful, thank you.

So one of the things that I was thinking about then is we've done a number of webinars about shared decision-making; and with shared decision-making, it is that. It's weighing the pros and cons, but adding the piece that you just spoke about; and that is also giving consideration to the person's values and how that influences the decision-making process – so very helpful, thank you very much.

I want to at this point do a quick survey of our audience and get some input from you guys. So the screen just changed; and if you were born in the months January through June, I'd like for you to type your answers on the new Chat window that opened up on the left. If you were born from July through December, I'd like for you to type in the box on the right. And think about this; consider your personal life and circumstances, and assume that you were creating a psychiatric advance directive or a general health care directive. What item or consideration would you want available should you need your advance directive activated?

Just kind of a quick – oh, I'm not looking for your birth date. What would be so important to you, you would want to include it in your advance directive. Would it be the care of your children? Would it be who could come visit or who couldn't come visit? Would it be ruling out a certain kind of procedure? So just brief statements – you all are doing great. It is looking like popcorn; that's fantastic.

What's the one thing you would want to include in a psychiatric advance directive? Put yourself in the shoes of the folks you serve, or perhaps it's your own shoes.

[Pause for responses]

That's great. I'm seeing things about considerations around the use of restraints or deferring to holistic treatment and ruling out neuroleptic meds or ruling out ECT. I'm seeing care of children, care of pets – those things that we love in our life – making sure *they're* okay while we're getting the support we need.

Oh, having access to go outside – these are some really great things to consider.

Being able to read your bible – so those things that are normalizing for your experience.

Because of time, we're going to have to move on; but we're going to review this list later and see what percolates as trends and use that to help us when we look at future work for recovery to practice, and what kinds of things might be helpful for providers to be aware of. Thank you so much for participating in that popcorn chat. Let's go ahead and move forward to our next question.

As people were creating this list, one of the things I've heard from other providers is that they're afraid that people will put dangerous or outrageous content in their psychiatric advance directive. So what should be

included, or is there anything that's not allowed in a psychiatric advance directive? Is it better to put in what you want, or is it better to put in what you don't want?

Pat?

Well, I think you put in both – what you want and what you do not want – because you're making instructions; you're letting people know what works for you and what doesn't work for you. One reason I like forums is because it really kind of cues people in to what's possible to put into a directive. So like in our Minnesota forum, we include things about techniques that help calm you; past trauma that will raise concerns for you in treatment; and then the things that people expect to be in a directive – your wishes regarding medications, not just what medications but dosages, side effects to look out for. If I'm giving my agent permission to agree to a new medication for me, here are the things I want my agent to be aware of; and this is when I want my agent to say, "That's not working," or, "We don't want to try this anymore."

So you can do a range of instructions regarding treatment. I notice a lot of people said, "I want to be able to go outside; I want to be able to see the sun." That's certainly something that can be put in a directive. I think it's important to understand that you don't get more rights in a directive than you have otherwise. So if you're not incapacitated and you're in the hospital and you say you want to go outside, you might hear something like, "We don't have any staff available right now; if somebody is available later, then we will see what we can do."

I guess the point there is put in what works for you. It doesn't have to just be medical language or anything like that. One of the reasons that's important is it lets people who are working with you know about you. So there are a range of things that can be put in.

The slide says, "Discuss reasonableness." I think you have to consider what's reasonable and what's not. I remember a client one time in the past who wanted to put in all kinds of instructions about opiates that she wanted when she was in the hospital. I had to explain to her, "That's not going to fly because your doctor's just not going to prescribe that for you." That was somebody who was still getting over substance addiction. So reasonableness is a factor, but it's not the only factor.

I think one advantage for people who do psychiatric directives -- compared to, say, me doing my end-of-life decision-making and I've never done end of life before – is people who are writing psychiatric directives often have a very good idea of what doesn't work and what does work.

Yeah, I'll just add to that; this is Marie. I think when I saw that question – after the first webinar, we reviewed some of the questions that we, unfortunately, hadn't gotten to. There were a lot of questions that were using language like, "What am I allowed to do, and what am I not allowed to do?" I want to point out to consumers, you're allowed to do anything you want. It's not a question of what you are and what you're not allowed to do; but you can think about, again, psychiatric advance directives. So let it be okay that you are giving directives; you are the person who's now trying to communicate to *other* people at whatever stage you're at, whether you're capacitated or incapacitated.

Think about it as you are directing this right now. You're trying to present information that no one else has ever heard because they don't know you that much. So don't necessarily think about should I put in what I want or don't want; put in whatever you believe is the most therapeutic for you. Try to be specific, and let it be okay that it's about you now.

Yeah, and I did notice quite a few people also in the popcorn chat wanted to be able to say who could be involved in their care and who could not; and that is something that you can put in. HIPAA recognizes the fact that directives can say who has access to records, for example. So it does allow you to really state who is important to you to be there. So your sisters can be there when you're in the hospital.

I think that's an important element to consider. We have had a question or two about the idea of agents and staff rules. Are there any rules about who can and cannot serve as your psychiatric advance directive

agent? And are peer specialists or other professionals able to serve as an agent? And then is it better to list an agent than to not?

So I'm wondering, Marie, would you give us some information about that?

Yeah, in general, we're thinking about the concept of conflict of interest. Some of us work in jobs where we have to know exactly what that means; but essentially, it's trying to get at the facts – the reality that there sometimes will be disagreements. They may not be full-blown arguments; but just let it be, again, that a provider may experience a competing interest – a provider, say a psychiatrist, psychologist, social worker – they are bound by ethics that can get confusing when they're compared to what you want. So they may want you to take a med to calm down, but you might not want to. Or a case manager or a peer specialist might try to help you get to live in a place that's easy for them to get to, but you don't really want to live there. So that's a natural competing interest. That's why your agent needs to be someone who best serves *your* interests, not the system's interests. We're not saying that happens all the time, but the answer to who could be the agent is based on that simple idea.

SAMHSA and most states feel as though *anybody* who provides service should not be the agent or representative, and they encourage all agencies to develop policies that clearly say that. And it includes peer specialists or peer workers because they are employees of whatever agency you're currently at, whatever nonprofit, whatever hospital.

I saw a question over in the Chat box: "Can a non-clinical staff person be the agent?"

The question again is, is the person employed or not? So, yes, a parent can be an agent; a friend can be an agent. My husband is my agent. If I didn't have my husband, my niece could be my agent. It's the person you trust to advocate for you when you can't advocate for yourself. In New Jersey, we wrote our law such that all of the agencies in New Jersey have to have their own policies that go into their formal policy database.

Just to clarify – and, Pat, you can correct me – well, to get to the other piece, I guess, the other question. In some states, they don't require an agent; but you believe, based on what you said earlier, that a PAD is stronger if an agent or someone who represents the person is named in the advance directive. Is that correct?

Yes, I've seen cases where that makes all the difference. Just to back up a bit, some states' psychiatric directives are really run through an agent; so some states require the appointment of an agent, and the instructions are to the agent. In other states, like Minnesota, you can have instructions and/or an agent. So even if you didn't have an agent, there would be instructions for a care provider.

Again, this is another circumstance where you really need to check your state's law; but generally speaking, I think a PAD that has an agent is just a stronger PAD. There's someone in your corner; there's someone who can kind of roll with the punches. If a doctor is recommending a different treatment than something you had in your PAD, maybe something you didn't anticipate, someone who really levels the playing field by being able to talk to your providers at a point in time where you might not be able to so well or you're feeling overwhelmed.

I think a good agent can deal with the bureaucracy too; for example, negative decisions by insurers: We're not going to approve that med. So it just is really helpful to have that person in there in your corner, if that is somebody who you trust to really implement your instructions and wishes.

Sure, so do psychiatric advance directives only apply to hospitalizations; or do they apply to outpatient services as well?

This is Marie. I think that in the first webinar, we stressed that if you think about early intervention and prevention, in fact we're trying to make a psychiatric advance directive apply way before crisis. So my

psychiatric advance directive literally goes into effect the minute I think that I don't remember which meds I took, and I may not be anywhere near a crisis. So my directive says at that point, it's not that I'm incapacitated; it's not that I'm dangerous. It's that I need help, and I want my husband to be the one to take over. Okay, she took it at this time, blah, blah, blah. You do not need – your definition of capacitated is the one that matters. We're not actually at legal yet.

So someone asked the question: "Does the doctor have to sign it?"

Absolutely not, the doctor has got nothing to do with it. The person who has to sign it is you and the person who is notarizing it, and someone else is just witnessing that you are capable right now. So again, think of it in terms of early intervention – as early as possible. Who do you trust, and who do you want to take over if you don't think you can anymore?

I did see on a previous slide a question about overriding a PAD, and I think that's a (audio break). A doctor can't override. A doctor can say, "I'm not going to follow this instruction because...." In many states, they have to document why in the person's chart. But that doesn't invalidate the agent; that doesn't invalidate the document itself. It may mean that that doctor is refusing to carry out a particular instruction, but that doesn't mean that the whole document is invalid. Really only a court could make that determination.

That seems like a really important point, and one of the things that is surprising is there were a lot of people who – I mean, part of the interest for this topic is because people have heard about psychiatric advance directives, but they don't have a strong place in our system. What are organizations doing to promote acceptance of psychiatric advance directives? What are the things that we can do to have psychiatric advance directives be taken more seriously?

This is Marie. I think I have to talk about the advocacy because it was vital in Jersey that it was organized advocacy. The way we did it was really coalitions of organizations that generally have a sense of consumer empowerment, and then compromising with organizations that might have had some of that tension that we talked about earlier. So a lot of people presume that there's going to be a lot of tension between docs and themselves. It actually doesn't play out that way; it hasn't been that way because people are talking about preferences, and they're talking about very benign things. It's not that hard to get me to be with my sister. It's not hard; and once someone knew that my sisters were my lifeblood, most compassionate providers go along with that. Family members often just don't understand things.

So I think the whole thing is coalition building. And the way that you find those organizations is very often through the National Disability Rights Network, where Pat works at the Minnesota chapter of that. You can also go to the Bazelon Center for Mental Health Law. The links for all these websites are going to be at the end.

Pat, did you have any thoughts?

I just want to add one thing. I want to put in a plug for better medical education on PADs. A surgeon would never operate on someone without informed consent. Asking people, "Do you have a directive; and if you don't, here are some reasons why you should have one," should just be something that people who are medical professionals and mental health professionals are educated on so that it becomes second nature to ask, "Do you have a directive? What's in your directive? We'll do the best we can to honor it."

That would be fantastic to have that happen universally, wouldn't it? I want to point out that when folks download the presentation, they'll have access to these links and reports that go deeper into the subject of psychiatric advance directives; and that we provided links to some templates.

Pat, you've mentioned a couple of times that forms are really helpful. And I think that it's important for folks to know that even as a state is working to maybe standardize a form, they don't need to reinvent the wheel. It can be personalized, but you probably want to start by looking at things that are working in other places.

Now, I want to move into some of the new questions that have come up during today's topic. Some of the questions have been about legal specifics. So does a psychiatric advance directive have to be registered somewhere for it to be implemented, Pat?

I think there are around 15 states that have registries; so the vast majority of states do not have them, and there's no reason to have that as a requirement generally speaking. So whether or not it's valid I don't think turns on whether or not it's registered. If you, again, think about wills, it's a similar legal concept. There are lots of ways that people can provide their directive. They can have it on their phone; they can give it to their providers; it can be in their electronic medical record; it can be on their refrigerator. Their agent certainly should have a copy. So there are ways other than registries to get that directive out there.

My state doesn't have a registry; so I don't know very well how accessible they are, how well they work, are they an asset to the process or do they sometimes end up being a barrier because you can only get them from nine to five? I would be interested in hearing from others about that. So most states, no, don't require some sort of registration.

Thank you. Another question that came up is: "If I, as a provider – if somebody hands me their psychiatric advance directive, what am I supposed to do with it?"

This is Marie. Like any other piece of communication, I would say save it; put it somewhere. Like any other medical document, it should go into the medical record. This calls for all the docs, all the service provider agencies that you might want to have it. So for example, my primary care doc has it; my cardiologist has it. I say, "This goes in the record. I want you to know this about me. I want you to know me as a whole person."

So it's a communication device. You're going to count on it just as much as everybody else should be counting on it. If your state doesn't have a registry, still think of it as something that's for the future, in advance. Also, I suggest that they read it right in front of you so they can clarify anything that's unclear to them. Again, it's not only for when you're in crisis or already incapacitated.

So I think this issue is a really good one for providers to do some advocacy on. I was talking to a psychiatrist just a few days ago and said, "Where in the electronic medical record does the directive go?"

And he said, "Well, there's not really one place in an electronic medical record. There's not a designated place, and that's one of the problems. So I think in lobbying electronic medical record companies for better products, there should be something that there's a tab for your health care directive and it comes up. That's just one example I think where on a broader scale advocacy by provider organizations would be really helpful.

I just want to clarify. As an individual, my role as taking care of myself and being my own best advocate, I should keep a copy of my advance directive. But when I give it to a professional or when I'm in my professional role and someone hands me their psychiatric advance directive, I am obligated to put it in the medical record, make it part of the medical record. And right now, with electronic medical records, it would be helpful if we could standardize where the psychiatric advance directive was placed.

Yeah, and under Federal law, you have to take a directive and put it in your medical records. You also are supposed to ask your patients and clients, "Do you have a directive?" So you also have an obligation to sort of prompt that discussion.

Excellent, and so another question was: "If you are receiving co-occurring services for mental health and addiction disorder, one psychiatric advance directive is sufficient; or do they need to be separate? What if you have more than one possible provider, what should you do?"

Again, this is Marie. Your preference is to be all about you. So if you believe that you have a co-occurring mental illness and substance abuse issue, then you're going to write your directive with that assumption.

You're going to, again, give your preferences for what you believe will be most therapeutic for you. Again, everybody who might ever be in a medical situation – and again, this is assuming that you're already in crisis, but I'm still going to stress that we're trying to get way back even before then where you may tell your trusted representative, here's what I want you to do with naloxone. I want you to do Narcan immediately when you see X, Y or Z.

Again, it's about you. And when you're going to put something in your directive, you're not necessarily just saying is, "Do not restrain me." What you're trying to say is, "My preference, if you believe that I'm becoming too agitated, is to do X, Y and Z." You always want to give the provider what your preference is and why. So the reason why you don't want to be restrained might be because you had once been raped. Most people would understand that if you were agitated then restraining you is going to be traumatic.

So let me clarify. A piece of the information is really about how can the provider best help me avoid the worst possible outcome? So if what I am trying to do is avoid being restrained and I know that certain things help me calm down, then sharing that in the PAD is to my benefit. If I know if I can just have a few minutes alone, if I can have my blanket or if I can have some music playing or – one of the things that I do personally when I get agitated, is I have some aroma therapy scents and I'll just smell it. It helps me remember that I don't have to go someplace else, but I can stay very present. So those kinds of things are a way of avoiding escalation.

I had a call from a former client once who had a directive, ended up in the emergency room. Her directive was in her medical chart. She said, "My directive says I need to be in a space by myself when I'm in this condition." And the people in the emergency room said, "Okay, we'll see what we can do," and put her in a room where she was able to calm down instead of getting more agitated, which is – emergency rooms are good for that. So the fact that it was there and it was in her chart, and they found it and they read it and they said, yep, that's what it says to do, and there wasn't any good reason not to honor it, and it really helped her situation.

That's fantastic.

Well, you guys, this time has flown by. There's been *such* good information. I'm really, really grateful to SAMHSA for providing this opportunity for us to touch on this topic again. We are able to provide this through the Recovery to Practice initiative – which our task is to provide education, training and resources to professionals to help instill and integrate recovery-oriented behavioral health care practice across the service system.

The disciplines involved with behavioral health care are many, and a lot of those disciplines have contributed to the work that we do. And you all on this call can access the discipline-based curricula that's available, that's specific to Recovery to Practice, at the Recovery to Practice website. All of this work hinges tightly on SAMHSA's collaborative principles that were identified a couple of years ago through some deep discussion and input from people in all walks of life, in all disciplines, and people who walk this experience of moving towards recovery.

The 10 principles and dimensions of recovery are critical for improving our system of care. Recovery is a process of change through which individuals improve their health and wellness and live a self-directed life and strive to reach their full potential. So whether we're talking about psychiatric advance directives or criminal justice or evidence-based practices, it all starts with and in a discussion about are we moving in a way that's going to help people have a better life.

So our commitment through the Recovery to Practice initiative is to provide training and technical assistance to you all. We do that through these free webinars. We do it through a fantastic newsletter. Look for our latest edition, which will be coming out in January; and we'll be focused on criminal justice. We do it through having a helpful website that has all of the archived materials available to you. I mean, if you want to stay a continuous learner, you can be busy for months on the Recovery to Practice website.

And then don't forget, you can get credit for this work. I know that if you're a professional, you have to have CEUs or other types of continuing education hours. So click the link that's going to pop up on your

screen in just a moment so that you can take the quiz and get the credit because you've been here and you're absorbing this new information.

With that, I want to thank you all for participating in this webinar. Look for us in January to start a new series that will look at criminal justice topics. It's going to be interesting; some of them have people who represent service providers and people who have received services, and we hope that you'll be there.

Thank you so much and have a great week.

Marie, Pat, thank you for your expertise and sharing that with us. You all have a great day.

Thanks a lot.

Thank you.