BERRIEN MENTAL HEALTH AUTHORITY
PROCEDURE

SUBJECT: Psychiatric Advance Directive (PAD)	SECTION: 01-05-10 Page 1 of 2
APPLICATIONS: All Staff; All Network Providers EFFECTIVE DATE: 5/2007 APPROVED BY: _____ Chief Executive Officer REVISED: 8/07, 6/16, 9/16, 2/2022, 5/2026	REQUIRED BY: MDHHS Contract CARF

POLICY: It is the policy of Berrien Mental Health Authority (BMHA) to provide an opportunity for consumers to plan for their future and provide direction in their medical and psychiatric care if they become unable to direct it themselves. Consumers will be given the option to develop a crisis plan and/or an advance directive.

PURPOSE: To define the process to offer and assist consumers in the development of an advance directive for mental health services.

DEFINITIONS:

Psychiatric Advance Directive (PAD) A written document in which a competent individual gives instructions about his/her mental health care that will be implemented at some future time should that person lack the ability to make decisions for himself/herself or in which the competent individual designates an individual (*Patient Advocate*) authorized to make such decisions for them at some future time should that person lack the ability to make decisions for himself/herself.

Crisis Plan: A document which allows the consumer to provide directions for their future care, including decisions affecting their personal life when they are unable to provide for their own needs due to a hospitalization or incapacitating illness. This is distinct from an *Advance Directive* and is not intended to fulfill the requirements for an Advance Directive for medical care or psychiatric crisis planning.

Patient advocate: The person appointed under an Advance Psychiatric Directive to make mental health treatment decisions during times of incapacity. The patient advocate must accept this appointment in writing to be appointed.

Also see definitions in the procedure for ***Crisis Plan 02-05-02*** and ***Advance Medical Directives 01-06-00.***

STANDARDS:

All consumers with a mental illness who do not have a legal guardian or are not under age 18 receiving mental health services through BMHA will be given the information, tools, assistance and opportunity to develop a PAD. Policy and procedures will be amended as necessary to comply with changes. Customer materials related to Advance Directives will be updated and distributed within 90 days of an

identified change in state law. Agency staff will be provided training on an annual basis regarding Psychiatric Advance Directives.

PROCEDURE:

1. Consumers will be provided with written information on advance directives at intake and annually during the pre-planning phase of his/her person-centered plan and offered the opportunity to develop a PAD.

2. The consumer's response to the offer to develop a PAD will be documented in the consumer's medical record. Peer Support Specialists (PSS) may be offered as a resource to assist the consumer with completing the paperwork.

3. If a consumer wishes to develop a PAD, the clinician may assist the consumer with completing one or refer him/her to a peer support to assist him/her with developing the plan. A consumer can create a PAD by filling out the form provided from MDHHS. A PAD form must be witnessed by a person who is not employed at BMHA and signed by the consumer and Patient Advocate.

4. If a PSS is requested to assist a consumer in developing a PAD, the goal for PSS services/PAD development must be specified in the Preliminary Treatment Plan or Individual Plan of Service including amount, scope and duration and authorization request for a Peer Support.

5. When completed, the PAD will be scanned and added to the record. The PAD will be followed as closely as circumstances and the law allow.

6. If there is noncompliance with advance directive requirements, the consumer may file a grievance with the BMHA Customer Service Representative.

7. During a crisis, a BMHA staff will ask if the person has made a crisis plan, an advance medical directive, or psychiatric advance directive. If the consumer indicates that they do have one of these in place, BMHA staff will assist in ensuring that the advocate is contacted.

8. A BMHA professional that provides mental health treatment to a patient will comply with the patient's desires, as expressed in the patient advocate designation. However, the mental health professional is not bound to follow an expressed desire, if any of the following applies:
   - In the mental health professional's opinion, compliance is not consistent with generally accepted community practice standards of treatment.
   - The treatment requested is not reasonably available.
   - Compliance is not consistent with applicable law.
   - Compliance is not consistent with court ordered treatment.
   - In the mental health professional's opinion, there is a psychiatric emergency endangering one's life and compliance is not appropriate under the circumstances.

Forms: *Michigan Psychiatric Advance Directive Form (Attached)*

Reviewer: Office of Recipient Rights
Reviewed: 3/08, 3/09, 3/10, 4/11, 5/12, 5/13, 3/14, 5/15, 3/16, 3/17, 3/18, 3/19, 4/2020, 9/2021, 2/2022, 8/2023, 8/2024, 8/2025, 5/2026

Michigan

PSYCHIATRIC ADVANCE DIRECTIVE (PAD) FOR MENTAL HEALTH CARE

I, _____, am of sound mind and

(Print or type your full name)

I voluntarily make this designation.

APPOINTMENT OF PATIENT ADVOCATE

I designate _____, my _____,
(Insert name of patient advocate) (Spouse, child, friend …)

living at _____,
(Address of patient advocate)

telephone number _____, as my patient advocate.

If my first choice cannot serve, I designate _____,
(Insert name of patient advocate)

my_____, living at_____
(Spouse, child, friend …) (Address of patient advocate)

_____, telephone number _____, as my patient advocate.

GENERAL POWERS

My patient advocate can only make decisions for me if a physician and a mental health professional determine I cannot give informed consent for mental health care.

My patient advocate must sign an acceptance before he or she can act. I have talked over this appointment with the individuals I have chosen as patient advocate.

In making decisions, my patient advocate shall try to follow my wishes, whether I have talked about them or written them in this document or any other document.

I give my patient advocate power to agree to or refuse treatment as set forth below, and to pay for such services with my funds.

SPECIFIC POWERS

Following is a list of types of treatment. I can choose one or more, by writing my initials on the line. By my initialing a line, I give my patient advocate power to consent to or refuse that type of treatment. On the following pages, I can indicate my specific wishes concerning each type of treatment I initial here.

_____ The individual I have chosen as my patient advocate shall have access to any of my medical and mental health records to which I have a right, immediately upon signing an Acceptance. To grant such access, I appoint this individual as my "personal representative" as defined in the privacy provisions of the Health Insurance Portability and Accountability Act, and as my "authorized representative" as defined in the Michigan Medical Records Access Act.

_____ Outpatient therapy

_____ My admission as a formal voluntary patient to a hospital to receive inpatient mental health services. I have the right to give a three day notice of my intent to leave the hospital.

_____ My admission to a hospital to receive inpatient mental health services

_____ Psychotropic medication (psychiatric medicine)

_____ Electro-convulsive therapy (ECT)

_____ Placement in a group residence

_____ Seclusion and restraints

STATEMENT OF PREFERENCES

(Optional)

1. The doctor and mental health professional I want to make the decision if I am not able to give informed consent are:

_____.

2. If I need outpatient therapy, I prefer it to be provided by _____, in the following setting: _____.

3. If I need to be hospitalized for inpatient treatment, I prefer the following hospital:

_____.

4. If I need to be hospitalized, I prefer _____
to take me to the hospital.

5. If I need medication, I prefer to receive _____
at the following dose(s) _____. I **do not** want to receive the following medication or medications:
_____, because _____
_____.

6. If I have given my patient advocate authority concerning ECT treatments, I want the maximum number of treatments to be _____.
(Write " O" if you do not want ECT)

7. Additional wishes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

REVOCATION

(Initial one statement)

_____ I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

_____ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days notice of my intent to leave a hospital if I am a formal voluntary patient.

LIABILITY

It is my intent that no one involved in my care shall be liable for honoring my wishes as expressed in this designation or for following the directions of my patient advocate.

Photocopies of this document can be relied upon as though they were originals.

SIGNATURE

I sign this document voluntarily, and I understand its purpose.

Dated: _____

Signed: _____

(Your signature)

_____

(Address)

STATEMENT REGARDING WITNESSES

I have chosen two adult witnesses who are not named in my will; who are not my spouse, child, grandchild, brother or sister; who are not my physician or my patient advocate; who are not an employee of my life or health insurance company, an employee of a home for the aged where I reside, an employee of community mental health program providing me services or an employee at the health care facility where I am now.

STATEMENT AND SIGNATURE OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____

(Print name) (Signature of witness)

_____

(Address)

_____ _____

(Print name) (Signature of witness)

_____

(Address)

ACCEPTANCE BY PATIENT ADVOCATE

(1) This designation shall not become effective unless the patient is unable to participate in decisions regarding the patient's mental health.

(2) A patient advocate shall not exercise powers concerning the patient's care, custody and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

(3) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(4) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests.

(5) The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental heath treatment decisions are presumed to be in the patient's best interests.

(6) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.

(7) A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

(8) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(9) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, being Section 333.20201 of the Michigan Compiled Laws.

I, _____, understand the above
(Name of patient advocate)
conditions and I accept the designation as patient advocate or successor patient advocate for
_____, who signed an
(Name of patient)
advance directive for mental health care on the following date: _____.

Dated: _____

Signed: _____
(Signature of patient advocate or successor patient advocate)