

Wyoming Administrative Rules

Health, Department of

Mental Health Division

Chapter 1: Psychiatric Advance Directives & PAD Form

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RULES AND REGULATIONS FOR PSYCHIATRIC ADVANCE DIRECTIVES

CHAPTER 1

Section 1. Purpose. The Department of Health has promulgated these regulations relating to psychiatric advance directives to ensure the timely and appropriate implementation and application of the Wyoming Psychiatric Advance Directives Statute.

(a) Any adult who has decisional capacity to provide informed consent to or refusal of psychiatric restabilization measures or any other person who is, pursuant to the laws of this state or any other state, authorized to consent to or refuse psychiatric restabilization measures on behalf of a person who lacks the decisional capacity, may execute a psychiatric advance directive. The principles of autonomy and personal dignity of the person having capacity are morally and ethically binding for physicians and other health care providers.

Section 2. Reason. To directly involve individuals in addressing health care decisions should they lose capacity due to symptoms subsequent to a serious and persistent mental illness. To insure compliance with Wyoming Statute on Psychiatric Advance Directives, W.S. §35-22-301 through W.S. §35-2-308.

Section 3. Authority. The specific statutory authority is W.S. 35-22-310 through W.S. 35-22-308.

Section 4. Definitions. Unless the context otherwise requires, the following definitions shall apply in the interpretation and enforcement of these rules and regulations:

(a) “Act” shall mean W.S. 35-22-301 through W.S. 35-22-308 relating to psychiatric advance directives.

(b) “Adult” shall mean a person at or over the age of 18 or an emancipated minor who is competent to execute a directive.

(c) “Agent” means any person authorized in the psychiatric advance directive to make decisions on behalf of the person who executed the directive.

(d) “Attending Physician” shall mean a person licensed by the State of Wyoming to practice medicine and who is the physician that assists the declarant in executing a psychiatric advance directive by explaining the purposes and countersigning the form.

(e) “Decisional capacity” means a person’s ability to receive and evaluate information regarding treatment issues, and to communicate, either verbally or nonverbally, a decision. Capacitation is determined by a psychiatrist, unless a person has already been legally adjudicated as incapacitated.

(f) “Declarant” shall mean an adult who has the decisional capacity to provide informed consent to or refusal of psychiatric treatment or any other person who is, pursuant to the laws of this state or any other state, authorized to make psychiatric treatment decisions on behalf of a person, including

a minor, who lacks such decisional capacity and who has executed a psychiatric advance directive, and which declaration remains unrevoked.

(g) “Division” shall mean the Mental Health Division Office of the Wyoming Department of Health.

(h) “Health Care Provider” shall mean a person who is licensed, certified or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession.

(i) “Mental Health Professional” means a Psychiatrist, Physician, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Addictions Therapist, Licensed Professional Counselor, or Advanced Practice Psychiatric Registered Nurse.

(j) “Person” shall mean an individual and shall include any trustee, receiver, assignee, or other legal representative thereof but shall not include any agency of the United States Government.

(k) “Psychiatric advance directive” or “PAD” means an advance medical directive pertaining to the administration or refusal of psychiatric restabilization for the care and treatment of mental illness.

(l) “Psychiatric advance directive form” means the document provided by the Department that is printed on distinctive security paper and is filled out by the declarant and attending physician to execute a psychiatric advance directive.

(m) “Psychiatric health care facility” shall mean any hospice, hospital, intermediate care facility, psychiatric hospital, mental hospital, and community mental health center or as defined in W.S. 35-2-901.

(n) “Psychiatric Restabilization” means measures to restore mental function or to support mental health in the event of destabilization of mental health due to lack of appropriate treatment. Psychiatric restabilization measures may include administration of prescribed liquid medication orally, physical restraint, seclusion or crisis psychiatric counseling, or other measures as stipulated in the document.

Section 5. Procedure.

(a) Persons admitted to psychiatric health care facilities such as hospitals, group homes, or long-term care facilities must be offered information about psychiatric advance directives and how to complete such directives.

(b) A mental health professional will review this material with the individual and his/her desires regarding execution of a psychiatric advance directive.

(c) If the person desires to create a psychiatric advance directive, assistance will be offered by a mental health professional in completing the directive.

(d) The Division shall prepare a standard form for use by those wishing to prepare and execute a psychiatric advance directive. The Division shall provide the form to anyone requesting a copy. Such forms shall be kept at the Mental Health Division, the Wyoming State Hospital, and the Division shall make copies available to community mental health centers and other health care facilities, at their request.

- i. Any form for a psychiatric advance directive must include the following data:
 - A. The person's name, date of birth, and sex.
 - B. The person's eye and hair color.
 - C. The person's race or ethnic background.
 - D. The person's social security number.
 - E. The name of the current and last treating facility.
 - F. The name, address and telephone number of the person's attending physician and/or primary mental health professional(s).
 - G. The person's signature or mark, or, if applicable, the signature of a person authorized by law to execute a psychiatric advance directive.
 - H. The date on which the psychiatric advance directive was signed.
 - I. The person's directive concerning the administration or refusal of psychiatric restabilization measures, countersigned by the person's attending physician or mental health professional.
 - J. The name, address and telephone number of the person designated as an agent, if applicable, to consent to or refuse psychiatric restabilization measures for the person who has executed a psychiatric advance directive and the signature of that person indicating acceptance of this appointment.
 - K. Information that a psychiatric advance directive may be revoked at any time by the person who is the subject of the directive unless he/she is mentally incapacitated, as attested to by two mental health professionals, one of whom is the person's attending physician; or at any time by any other person who is, pursuant to state law, authorized to consent to or refuse psychiatric restabilization measures on behalf of the person who is the subject of the directive.
 - L. Completed advance directives will be witnessed by two persons who are not family members or employees of the psychiatric facility where the person is being treated.

(e) The "agent" identified in the psychiatric advance directive may not make mental illness treatment decisions unless the subject of the directive lacks capacity as attested to be two mental health professionals (one of whom is the attending physician) or by a court of law.

(f) Except to the extent that the right is limited by the declaration of any federal law, an agent has the same right as the declarant to receive information regarding the proposed mental illness treatment, and to receive, review, and consent to disclosure of medical records relating to that treatment.

(g) An agent may withdraw by giving notice to the declarant. If the declarant is incompetent at the time of the withdrawal, the agent may withdraw by giving notice to the attending physician or mental health professional. That person shall note the withdrawal in the medical record and on the psychiatric advance directive form. This person may rescind their withdrawal by executing an acceptance after the date of withdrawal reaffirming their acceptance of this responsibility. The agent will again give notice to the patient and attending physician or mental health professional.

(h) Mental health professionals shall comply with the psychiatric advance directive to the extent medically indicated under the direction of the attending physician or psychiatrist.

(i) Mental health professionals who in good faith comply with a psychiatrist advance directive shall not be subject to civil or criminal liability or regulatory sanction for such compliance.

(j) Compliance with a psychiatric advance directive shall not affect the criminal prosecution of any person otherwise charged with the commission of a criminal act.

(k) In the absence of a psychiatric advance directive, a person's consent to psychiatric restabilization measures shall not be presumed.

(l) A psychiatric advance directive for any person admitted to a psychiatric health care facility shall be implemented as directed by the psychiatric advance directive, pending further physician's orders. The psychiatric advance directive shall be deviated from only with the consent of the admitted person, his/her agent, the district court or when adherence to the directive threatens permanent physical injury.

(m) Neither a psychiatric advance directive nor the failure of a person to execute one shall affect, impair or modify any contract of life or health insurance or any annuity or be the basis for any delay in issuing or refusing to issue an annuity or policy of health insurance or any increase or premium thereof.

(n) A psychiatric advance directive may be revoked at any time by the person who is the subject of the directive unless he is mentally incapacitated or at any time by any other person who is, pursuant to the laws of this state or any other state, authorized to consent to or refuse psychiatric restabilization measures on behalf of the person who is the subject of the directive.

(o) A psychiatric advance directive shall be valid for a period not to exceed two (2) years from the date of execution unless reaffirmed by the person who executed the directive, in which case it shall be valid for two (2) more years from the date of reaffirmation.

(p) When a mental health professional is not willing to follow a person's advance directive, he/she is obligated to transfer patient care to a mental health professional who can and will follow the advance directive.

(q) Psychiatric health care facilities shall provide education for their staff and volunteers on issues regarding psychiatric advance directives.

(r) Revocation may be accomplished by:

- i. written revocation signed by the person or legal designate;
- ii. by verbal expression in the presence of an adult witness who signs and dates a written confirmation of the person's or legal designate's verbal expression to revoke the advance directive;
- iii. by verbal expression over the telephone with a witness who signs and dates a written confirmation of the verbal expression to revoke the psychiatric advance directive.

**PSYCHIATRIC ADVANCE DIRECTIVE DECLARATION
TO MY FAMILY, MY PHYSICIAN, MY LAWYER
AND ALL OTHERS WHOM IT MAY CONCERN**

Declaration made this ____ day of, _____ 20 ____.

I, being of sound mind, willfully and voluntarily make known my desires for mental health treatment(s) to be followed should it be determined by two physicians, one of whom is my attending physician, that my ability to receive and evaluate information effectively or communicate decision is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. I understand that any treatments would be toward the goal of psychiatric restabilization as a way of restoring my capacity and optimal mental health functioning. I further understand that psychiatric restabilization may include administration of prescribed liquid medication by mouth or injection, administration of prescribed medication orally, physical restraint, seclusion or crisis psychiatric counseling and that in the statements below I may give or refuse consent to any of these or other treatment options to which I stipulate.

I understand that I may revoke this declaration at any time unless I have been declared to lack capacity to give or withhold treatment by two physicians, one of whom is my attending physician.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to symptoms of a diagnosed mental disorder. The symptoms may include the following:

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding medications are as follows:

____ I consent to the administration of medications.

____ I consent to the administration of the following medications: _____

I do not give consent to the administration of medications.

____ I do not give consent to the administration of the following medications: _____

Conditions or limitations: _____

Should I become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder and my behaviors become dangerous to myself or others, or should I become incapable of providing for my basic need. In this case I would give consent for the following treatment(s):

____ Physical Restraint ____ Seclusion ____ Crisis Psychiatric Counseling

Other: _____

In this case I would not give consent for:

____ Physical Restraint ____ Seclusion ____ Crisis Psychiatric Counseling

Other: _____

Should I become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder I hereby appoint:

Name _____ Address _____

Telephone Number(s) _____ to act as my agent in making decisions regarding my mental health treatment. I understand that this person will gain this appointment only if I am declared to lack capacity by two physicians, one of whom will be my attending physician.

My agent is authorized to make decisions that are consistent with the wishes I have expressed in this declaration, or, if not expressed, as are otherwise known to my agent. If my wishes are not expressed and are not otherwise known by my agent that person is to act in what he or she believes to be in my best interest.

ACCEPTANCE OF APPOINTMENT AS AGENT

I accept this appointment and agree to serve as the agent to make decisions about mental health treatment for, _____. I understand I have a duty to act consistent with the desires of this individual as expressed in this appointment. I understand this document gives me the authority to make decisions about mental health treatment only while this person is incapable as determined by a court or two physicians. I understand that he or she may revoke this declaration in whole or in part at any

time and in any manner when he or she has capacity to make decisions.

Signature of Agent

Date

This document has significant medical, legal and possible ethical implications and effects. Before you sign this document, you should become completely familiar with these implications and effects. The operation, effects, and implications of this document may be discussed with a physician, a lawyer, and a clergyman of your choice.

Signed Date _____ Address _____
City, County, and State of Residence

The declarant has been made personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness

Date

Witness

Date

MENTAL HEALTH PROFESSIONAL STATEMENT REGARDING CAPACITY

It is my professional opinion at this time that this person has the capacity to make this declaration:

_____ Yes _____ No

Signature of Psychiatrist/Mental Health Professional

Date

Name of Provider/Institution

Telephone Number of Provider/Institution

Name,
Address, and Telephone Number of Attending Physician/Psychiatrist

Please complete the following information to assist your physician and other psychiatric personnel to rapidly identify you as the declarant of this Psychiatric Advance Directive:

Date of Birth _____ Sex _____ Eye Color _____ Hair Color

Racial or Ethnic Background _____ Social Security Number

Copies of this document are in the following places (i.e., family members, doctors office, hospitals, mental health centers....)