FORTY-SEVENTH LEGISLATURE SB 749/a
FIRST SESSION, 2005

February 25, 2005

Madam President:

Your PUBLIC AFFAIRS COMMITTEE, to whom has been referred

SENATE BILL 749

has had it under consideration and reports same with recommendation that it DO PASS, amended as follows:

1. On page 4, strike lines 7 through 14 in their entirety and insert in lieu thereof:

"M. "mental health treatment" means services provided for the prevention of, ameliorations of symptoms of, or recovery from mental illness or emotional disturbance, including electroconvulsive treatment, treatment with medication, counseling, rehabilitation services or admission to and retention in a facility for care or treatment of persons with mental illness, if required;

N. "mental illness" means the substantial disorder of the person's emotional process, thoughts or cognition, which grossly impairs judgement, behavior or capacity to recognize reality, but "mental illness" does not mean developmental disability;".

2. On page 4, strike lines 21 and 22 in their entirety.

3. Reletter the succeeding subsections accordingly.

4. On page 23, line 24, strike "of sound mind" and insert in lieu thereof "a person with capacity".

5. On page 24, line 3, after the period insert:

"If a guardian or an agent is appointed to make mental health decisions for me, I intend this document to take precedence over other means of ascertaining my wishes and interests.

The fact that I may have left blanks in this directive does not

affect its validity in any way. I intend that all completed sections be followed. I intend this directive to take precedence over any other directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if one health-care provider and one mental health professional find that I am an incapacitated person.

I understand there are some circumstances where my provider may not have to follow my directive, specifically, if the treatment requested in this directive is infeasible or unavailable, the facility or provider is not licensed or authorized to provide the treatment requested or the directive conflicts with other applicable law.".

6. On page 24, line 5, strike "my attending" and insert in lieu thereof "a".

7. On page 24, lines 5 and 6, strike "or psychologist and another physician or psychologist" and insert in lieu thereof "and a licensed mental health professional".

8. On page 24, strike lines 14 through 25, on page 25, strike lines 1 through 3 and insert in lieu thereof:

"I understand that "mental health treatment" means services provided for the prevention of, ameliorations of symptoms of, or recovery from mental illness or emotional disturbance, including but not limited to electroconvulsive treatment, treatment with medication, counseling, rehabilitation services or admission to and retention in a facility for care or treatment of persons with mental illness, if required.

Preferences and Instructions About Treatment, Facilities and

Physicians

I would like the physician(s) named below to be involved in my treatment decisions:

Dr. _____Contact information_____

Dr. _____Contact information_____

I do not wish to be treated by Dr. _____

Other Preferences: _____

Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name: _____ Profession_____Contact

Information_____

Name: _____ Profession_____Contact

Information_____

Preferences and Instructions About Medications for Mental Health Treatment (*initial and complete all that apply*)

____ I consent, and authorize my agent or surrogate (if appointed) to consent, to the following medications: _____

____ I do not consent, and I do not authorize my agent or surrogate (if appointed) to consent, to the administration of the following medications: _____

____ I am willing to take the medications excluded above if my only reason for excluding them is the side effects, which include _____, and these side effects can be eliminated by dosage adjustment or other means.

____ I am willing to try any other medication the hospital doctor recommends.

____ I am willing to try any other medications my outpatient doctor recommends.

____ I do not want to try any other medications.

Medication Allergies

I have allergies to, or severe side effects from, the following:
_____

I have the following other preferences or instructions about medications:
_____

Preferences and Instructions About Hospitalization and Alternatives (*initial all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on*)

_____ In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalization.

_____ I would also like the interventions below to be tried before hospitalization is considered:

_____ Calling someone or having someone call me when needed.

Name: _____ Telephone: _____

___ Having a mental health service provider come to see me
___ Going to a crisis triage center or emergency room
___ Staying overnight at a crisis respite (temporary) bed
___ Seeing a provider for help with psychiatric medications
___ Other, specify: _____

Authority to Consent to Inpatient Treatment

I consent, and authorize my agent or surrogate (if appointed) to consent, to voluntary admission to inpatient mental health treatment for _____ days

(Sign one)
____ If deemed appropriate by my surrogate or agent (if appointed) and treating physician _____(Signature)

or

___ Under the following circumstances (specify symptoms, behaviors or circumstances that indicate the need for hospitalization)
_____

_____ (Signature)

___ I do not consent, or authorize my agent or surrogate (if appointed) to consent, to inpatient treatment
_____(Signature)

Preferences and Instructions About Use of Seclusion or Restraint

I would like the interventions below to be tried before use of seclusion or restraint is considered (*initial all that apply*)

___ "Talk me down": one-on-one
___ More medication
___ Time out/privacy
___ Show of authority/force
___ Shift my attention to something else
___ Set firm limits on my behavior
___ Help me to discuss/vent feelings
___ Decrease stimulation
___ Offer to have neutral person settle dispute
___ Other, specify _____

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen (*choose "1" for first choice, "2" for second choice, and so on*):

___ Seclusion
___ Seclusion and physical restraint (combined)
___ Medication by injection
___ Medication in pill or liquid form

In the event my physician decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in this directive. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.

Preferences and Instructions About Electroconvulsive Therapy

My wishes regarding electroconvulsive therapy are (*sign one*):

___ I do not consent, nor authorize my agent or surrogate (if appointed) to consent, to the administration of electroconvulsive therapy. _____(Signature)

___ I consent, and authorize my agent or surrogate (if appointed) to consent, to the administration of electroconvulsive therapy. _____(Signature)

__ I consent, and authorize my agent or surrogate (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions:
_____

_____(Signature)

Preferences and Instructions About Who Is Permitted to Visit

If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name: _____
Name: _____
Name: _____

I understand that persons not listed above may be permitted to visit me.

Additional Instructions About My Mental Health Care

Other instructions about my mental health care:

In case of emergency, please contact:

Name:_____ Address:_____

Work Telephone:_____ Home telephone:_____

Physician:_____ Address:_____

Telephone:_____

The following may help me to avoid a hospitalization:

I generally react to being hospitalized as follows:

Staff of the hospital or crisis unit can help me by doing the following:

Refusal of Treatment

I do not consent to any mental health treatment.

_____
(Signature)".

9. On page 25, lines 14 and 15, strike "my attending physician or psychologist and another physician or psychologist" and insert in lieu thereof "a physician and a licensed mental health professional".

10. On page 37, line 8, after "physician" insert "chosen by the principal, agent or surrogate".

11. On page 37, between lines 8 and 9, insert a new subsection to read:

"H. A mental health-care provider may only decline to comply with an individual instruction or health-care decision for any of the following reasons:

(1) the treatment requested is infeasible or unavailable;

(2) the facility or provider is not licensed or authorized to provide the treatment requested; or

(3) the treatment requested conflicts with other applicable law.".

12. Reletter succeeding subsections accordingly.

13. On page 42, line 16, strike "psychologist" and insert in lieu thereof "a mental health professional licensed to practice in the state".

14. On page 42, line 17, strike "be incapable" and insert in lieu thereof "lack capacity".

15. On page 43, line 7, strike "(Is)(Is not) incapable" and insert in lieu thereof "(Does)(Does not) have the capacity".

16. On page 44, strike lines 14 through 16 in their entirety and insert in lieu thereof:

"Our determination that the principal does not have the capacity to participate in the principal's mental health treatment decisions is based on:

1. the principal's ability to understand and communicate the nature of the proposed health care or mental health treatment described as:

_____

_____

2. the principal's ability to understand and communicate the consequences of the proposed health care or mental health treatment described as:

_____

_____

3. the principal's ability to understand and communicate the significant benefits, risks and alternatives to the proposed health care or mental health treatment described as:

_____

_____

4. the principal's ability to understand and communicate a choice about the proposed health care or mental health treatment described as:

_____

_____",

and thence referred to the JUDICIARY COMMITTEE.

Respectfully submitted,

_____
Dede Feldman, Chairman

Adopted_____ Not Adopted_____
(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 6 For 0 Against
Yes: 6
No: 0
Excused: Ingle, Komadina, Taylor
Absent: None