

UNIVERSITY LEGAL
Protection & Advocacy Program



SERVICES
for the District of Columbia

RECOVERY RIGHTS

2010

A Guide for Adult Consumers of Mental Health Services
in the District of Columbia

University Legal Services

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University Legal Services (ULS)

University Legal Services (ULS) is the federally mandated Protection and Advocacy Program for individuals with disabilities in the District of Columbia (D.C.). ULS is a private, non-profit organization and is not affiliated with the D.C. Department of Mental Health (DMH) or any other agency or health care provider.

ULS staff includes advocates and attorneys who investigate claims of abuse, neglect and rights violations, and provides referrals and legal representation without charge to eligible D.C. residents with mental illness. Among other things, ULS may be able to help you file a grievance, develop a treatment or discharge plan that is right for you, or refer you to other advocates who can help you.

ULS believes in the dignity of all individuals, regardless of their diagnosis. If you are a consumer of mental health services, ULS believes you should be able to:

- live and receive treatment and services in your community;
- direct your care and treatment;
- decide for yourself where you want to live, who you want your treatment team to be, and what medications you want to take; and
- recover from mental illness with the same rights as anyone else living in the District of Columbia.

Thank you to the PAIMI Advisory Council, and especially to Martha Ludden, who worked tirelessly to create this book. Special thanks to Laurie Davis at the Public Defender Service – Mental Health Division, who contributed to the section on civil commitment.

This guide is dedicated to the memory of Nancy Lee Head, who devoted her life to promoting social justice and eliminating the stigma of mental illness.

For more information or to request additional copies of this manual, please contact:

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Table of Contents

I.	INTRODUCTION	4
II.	YOUR BASIC MENTAL HEALTH CARE RIGHTS	
	A. Your Right to Informed Consent	5
	B. Your Right to Refuse Medication	5
	C. Your Right to Have a “You-Centered” Treatment Plan	7
	D. Your Grievance Rights	7
	E. Your Right to Have an Advance Directive	10
	F. Your Right to Challenge Your Guardianship	11
III.	COMMUNITY-BASED MENTAL HEALTH SERVICES	
	A. Selecting and Enrolling in a CSA	12
	B. DMH Emergency/Crisis Care	13
	C. Housing Options	13
IV.	INPATIENT MENTAL HEALTH SERVICES	
	A. Voluntary versus Involuntary Hospitalization	15
	B. Seclusion and Restraint	18
	C. Discharge Planning	19
V.	CONCLUSION	19
VI.	RESOURCES	
	A. Core Service Agencies (CSAs)	20
	B. Community Resources	21
	C. Legal Assistance	23
VII.	FORMS	
	A. FAIR Form B Consent to Representation for a Grievance	26
	B. FAIR Form C Consumer’s Form for Filing a Grievance	27
	C. FAIR Form E Decision to Appeal	28
	D. Psychiatric Advance Directive Form	29
	E. Power of Attorney Form	38
VIII.	GLOSSARY	43

I. INTRODUCTION

- Have you ever been hospitalized against your will?
- Have you ever been forced to take medication you didn't want to take?
- Have you ever had to live where someone else wanted you to live?
- Have you ever been told you can't be in a rehabilitation program because you have a mental illness diagnosis?
- Have you ever been abused or neglected by the people who provide your mental health care?

If you answered "yes," to any of these questions, this book is for you!

We hope you will find this book useful as you walk your own personal road of recovery and self-advocacy. This book outlines the rights of individuals over the age of 18 living with mental illness in the District of Columbia. There are spaces throughout the book where you can take notes about your mental health care and the issues that concern you.

If you have questions or concerns about your rights as a mental health consumer, you may call University Legal Services at 202-547-0198 between 9:00 a.m. and 5:00 p.m., Monday through Friday, and speak with the intake specialist.

II. YOUR BASIC MENTAL HEALTH CARE RIGHTS

Whether you are receiving mental health services from an inpatient facility like St. Elizabeths Hospital, a psychiatric unit in a private hospital, a community-based mental health center, a residential program or a private mental health care provider, you have the right to be treated with dignity and respect at all times. This includes the following rights that are protected by federal and D.C. law:

- You have the right to participate in and guide your treatment planning.
- You have the right to vote.
- In a hospital setting, you have the right to speak freely and visit with your family and friends, your attorney, religious leaders, your guardian, and anyone who plays the role of personal or legal representative.
- You have the right to socialize with men and women, unless a physician recommends otherwise.
- You have the right to make and receive confidential telephone calls. You have the right to make some long distance calls. If you need help making calls, you have the right to receive assistance.
- You have the right to communicate with everyone in your personal network by mail and e-mail, and have your privacy respected.

- You have the right to wear your own clothes, style your hair and apply your makeup the way you want to.
- You have the right to keep your own possessions and have your own storage space.
- You have the right to practice the religion of your choice or to not practice any religion at all.
- You have the right to go outdoors and get a reasonable amount of physical exercise.

A. Your Right to Informed Consent

Whenever a doctor prescribes medication, you have the right to ask questions about how the medicine will help you and how side effects could make you feel uncomfortable or harm you. If you have enough information to weigh the good and the bad effects of each medication you take, you can decide whether you want to take that medication. This is called “informed consent.”

TIP → **If you are having uncomfortable side effects from a medication, you have the right to ask your doctor if there is another medicine available that doesn’t cause these kinds of side effects.**

Also, you have the right to choose whether to take part in any other support or service that you receive as part of your mental health treatment. You can ask your psychiatrist or any other doctor questions to get more information about your treatment so that you can decide for yourself what you need and what helps you feel good.

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B. Your Right to Refuse Medication

You have the right to refuse medication in most cases, even if you have been committed by the court for treatment at St. Elizabeths Hospital or another inpatient facility. By law, a hospital can usually only force you to take medication if two professionals (one must be a psychiatrist) have found you to be incompetent. This means

that the two professionals have examined you and found that the symptoms of your illness prevent you from making your own decisions about your health care.

Even if the two professionals certify that you are incompetent, the hospital can only force you to take medication when a doctor or psychiatrist believes there is an emergency, and that giving you medication immediately is *necessary to prevent serious injury to you or to others*. If it is not an emergency, the hospital must get approval for the involuntary medication from a medication review panel.

If you are not in an emergency situation (described above) and a doctor wants to give you medication against your wishes, you have these rights:

- You must get written and spoken notice of services available for someone to advocate for you;
- You must have a chance to meet with a “Medication Review Officer” who was not involved in the decision to give you medication against your wishes;
- You must have 48 hours notice of this meeting;
- Your representative can be present at this meeting with you;
- After the meeting, you must get a written decision about the involuntary medication;
- You have the right to appeal the decision to medicate you against your will to a “Medication Review Panel,” which will meet and review the decision. The Panel will then order the doctor to stop giving you medication against your will until it has a chance to decide.

Your right to refuse medication is related to your right to informed consent (see page 5). Until two doctors find that you are “incompetent” or unable to make your own decisions about medication, you have the right to ask questions to find out how the medicine will help you, and what side effects come with taking the medicine. You have the right to get all the information you need to weigh the risks and the benefits of taking each medicine in the dosage the doctor wants to give you.

While, generally, you have the right to refuse to take medicine, if you are under “outpatient commitment,” you may be ordered to comply with your treatment plan, which may require you to take medication. However, your outpatient status should not be revoked just for not taking your medicine. The law says that outpatient commitment cannot be revoked unless it is shown that you have become a danger to yourself or others.

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C. Your Right to Have a “You-Centered” Treatment Plan

Whether you are in an inpatient or a community-based treatment program, you have the right to develop a treatment plan that is right for you. It should be based upon your strengths and skills, and flexible enough to change with your needs, goals and accomplishments. As you recover, you have the right to a treatment plan that grows with you.

No matter what your diagnosis, you have the right to recover at your own pace, in your own way. This means:

- You have the right to know your diagnosis;
- You have the right to know the core symptoms that make up your diagnosis; and
- You have the right to know your treatment options and what you can realistically hope for in recovery.

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D. Your Grievance Rights

Whether you are receiving mental health services from an inpatient hospital, such as St. Elizabeths Hospital, or a community-based provider, such as a core services agency (“CSA”) or the Comprehensive Psychiatric Emergency Program (“CPEP”), you can file a “grievance” if you believe the provider has failed to give you proper care, has violated your rights, or has treated you improperly in some way. For example, you may file a grievance if you feel that:

- You have been abused physically, sexually or verbally
- You have been denied access to service(s);
- You have been treated unfairly or retaliated against;
- You are forced to live in unsafe conditions;
- Your CSA or representative payee is mishandling your money;
- Your treatment team is not considering your wishes when making your treatment plan;
- There is anything about your treatment that makes you feel like the provider is not treating you with dignity, privacy, autonomy, or respect. (See “Your Basic Rights” on page 4-5.)

TIP → If you think your rights have not been respected, you have the right to file a grievance about it.

There is a grievance form on page 26-27. You can use the form in this book or get a grievance form from your service provider, DMH, or one of the advocacy organizations listed on page 23-25. You can fill out the form yourself, or you can tell someone on staff what you are complaining about and have the staff member fill out the grievance form on your behalf.

On the grievance form, you can briefly write what you are complaining about, and what you want done about it. You do not have to use any formal language. You can ask for a change in your treatment, a change in your provider's policies, an apology or acknowledgement of wrongdoing, or that some disciplinary action be taken against a staff person who violated your rights. In most cases, you cannot get money from your provider or be released from a hospital by filing a grievance. When you have filled out the grievance form, you should give it to a supervisor who works for your service provider.

TIP → If you need help filling out the grievance form, you can call the Consumer Action Network (CAN), the DMH Office of Consumer and Family Affairs (OCFA) or ULS. If you would like an attorney to represent you in your grievance, you can call ULS.

You never have to discuss your grievance with the person(s) you are complaining about if you don't want to. Along the same lines, your service provider is PROHIBITED from retaliating against you in any way for filing a grievance! If you believe your service provider has retaliated against you for filing a grievance, please contact ULS.

Once you have submitted your grievance, the provider has 10 business days to investigate, review and respond to the grievance. If the grievance contains allegations of abuse, neglect, or denial of service, the provider has only 5 business days to investigate, review and respond to the grievance.

If you are not satisfied with the provider's response to your grievance, you have 10 business days to appeal by asking DMH to conduct an "external review" of your grievance. You request the external review by filling out FAIR form "E" (found on page 28) and giving it to your service provider. If you do not want to be in the same room as

your service provider during the external review you can say this on form E by checking the box that gives this option.

You have the right to be represented during the external review by a peer advocate, an attorney, a friend, a relative or even a trusted staff person. Be sure to talk to the person so they understand they will be representing you. Everyone gets a chance to talk and express their point of view at the external review.

TIP → The external review can be either an informal hearing or mediation. You may request which kind of external review you want.

Mediation. In mediation, the external reviewer will try to help you and your service provider come to an agreement to resolve the grievance. You can stop the mediation at any time. If you reach an agreement with your service provider at the mediation, the external reviewer will write up the agreement at the mediation and will give everyone a copy.

Hearing. If you have an external review hearing, you can present evidence and call witnesses at the hearing. If your service provider calls witnesses, you can question those witnesses. The hearing is fairly informal.

After the external review hearing, the external reviewer must give you the findings and decision for the external review, known as the “advisory opinion.” The advisory opinion must be completed within 5 business days of the hearing, although the external reviewer will often take longer. After you get the external reviewer’s decision, you have 5 business days to submit any comments on the advisory opinion. The DMH Director reviews the advisory opinion and your comments, and issues a final opinion that may either agree or disagree with the external reviewer’s advisory opinion. The DMH Director is supposed to issue the final decision within 10 business days after the advisory opinion, but it often takes a lot longer.

If you do not like the DMH Director’s final decision, D.C. law allows you to request a “fair hearing” of your grievance, but DMH has not yet set up this process. Until the process has been set up, you may request the fair hearing by writing to the Office of Consumer and Family Affairs at DMH.

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E. Your Right to Have an Advance Directive

A Psychiatric Advance Directive (PAD) is a written legal document that allows you to state your wishes and preferences for your mental health treatment at a later time when, due to a decline in your mental condition, you are unable to direct your care. It has all the information you want doctors to know about you if, at some point in the future, you are in *crisis* and are *not able to give doctors this information*. A PAD is also a tool for understanding what interventions are helpful to you and what interventions are not.

A PAD does NOT affect your right to make treatment decisions when you are capable of making such decisions. Your PAD only begins to take effect when two physicians (one must be a psychiatrist) certify that you are not capable of making health care decisions.

Your advocate can help you prepare a Psychiatric Advance Directive. There is a form for a PAD on page 29. This document tells doctors and other treatment providers important information like:

- who to contact in an emergency;
- what medications you have been taking;
- what medications have been helpful in the past to get you through a crisis;
- what methods help you feel better when you are in a crisis, such as lying down, listening to music, exercising, etc.; and
- how to contact your guardian (if you have one) or someone that has power of attorney for health care (see page 38 for the power of attorney worksheet).

To become a legal document, you must sign your PAD in the presence of two adult witnesses. No one from your treatment team or service provider can be a witness. A family member can be one of the witnesses, but you must have a second witness who is not related to you by blood, marriage or adoption.

Remember to make sure your treatment team knows you have a PAD and that your team understands your wishes. Remind them of this periodically. Make sure you, your attorney-in-fact (the person you want to be responsible for carrying out your wishes when the PAD goes into effect), your provider(s), and anyone else you think is important have a copy of your PAD.

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F. Your Right to Challenge Your Guardianship or Conservator

If the Probate Court has appointed a conservator (someone who takes care of your money and property) or a guardian (someone who makes decisions for you) to help you, you may ask the court to end the conservatorship or guardianship because you feel you no longer need someone to make decisions for you, or appoint a new one if you are unhappy with the one you have. The process for doing this is called the “petition post appointment” process.

To begin this process, you or any other interested person, such as a relative or case worker, must complete a “Petition Post Appointment” and file it with the clerk in the Probate Court of the D.C. Superior Court. You can contact the clerk of the Probate Court for a copy of the form. The form is also available online at: http://www.dccourts.gov/dccourts/docs/probate_II-Q.pdf. The court will then hold a hearing before it decides what to do. A hearing is the meeting where the court hears what the people involved, such as the guardian or conservator, relatives, and you, have to say.

The court may appoint a new guardian if it finds that your guardian did not act as you would have acted if you were able to do so, abused her powers, did not provide for you, or interfered with your progress or participation in programs in the community.

If you have concerns about your guardian or conservator, you may contact the Guardianship Assistance Program at the Probate Court at (202) 879-9407. The Guardianship Assistance Program monitors the care of adults placed under guardianship in the District of Columbia. It also attempts to provide information and support to guardians, wards and family members.

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III. COMMUNITY-BASED MENTAL HEALTH SERVICES

The Department of Mental Health (DMH) provides FREE and sliding scale-based mental health care for qualified residents of the District of Columbia.

To get free mental health care from DMH, call the DMH ACCESS HELPLINE at (202) 671-3070 or 1-888-793-4357.

DMH has certified 28 private mental health centers (listed at page 20) to provide mental health services in the community. These core services agencies (CSAs) all

provide assessments, medication, counseling and community support. Many CSAs also provide other types of services, like group therapy, day treatment and crisis services.

A. Selecting and Enrolling in a CSA

To enroll in a CSA, call the DMH Access HelpLine at (202) 671-3070 or 1-888-793-4357. You can also go to any of the CSAs listed on page 20. If you go to a CSA to enroll, you have the right to get any information you need about other CSAs in order to choose the right CSA for you.

The Access HelpLine staff will ask you for your name, address, phone number and insurance coverage and may ask you some other questions about what assistance you are seeking. Then they will tell you which CSAs have openings for new patients. You have the right to ask several questions about the CSA, such as:

- its location;
- what types of services and specialty services they offer;
- what type of people they serve;
- how they rate in consumer satisfaction; and
- which doctor you would see and some information about the doctor.

You can ask the Access HelpLine staff as many questions as you need to make an informed choice about where you want to go to get your mental health services. The Access Helpline staff can enroll you in a CSA and give you your first appointment. By law, the first appointment must be within 7 days of your enrollment. If you tell the Access HelpLine staff that you have an urgent need, a CSA staff member must meet with you the day you enroll.

Once you are enrolled, you will meet with a psychiatrist and begin to discuss your condition and your recovery. You will develop a treatment team and other professionals may be added such as:

- therapists
- employment counselors
- community support worker

Your treatment team, with you as captain, will develop a treatment plan called an Individual Recovery Plan (IRP). You have the right to participate in your treatment planning. Your IRP will be developed over time, as you meet with the different people on your treatment team. You have the right to know what your diagnosis is and how your treatment team plans to help you walk your own personal road of recovery. If you need

help with your IRP, you can call ULS or the other advocacy organizations and peer advocates in the Resources section on page 20-25.

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B. DMH Emergency/Crisis Care

You can always call 911 if you are having an emergency. However, you also have other choices. In an emergency – if you are afraid you could hurt yourself or someone else – you can call the DMH Access Helpline at 202-671-3070 or 1-888-793-4357.

The Mobile Crisis Unit operates between 9:00 a.m. and 1:00 a.m., 7 days a week, and emergency technicians should come to you within an hour. They can take you to CPEP (the Comprehensive Psychiatric Emergency Program) if you want to go there. CPEP is located behind D.C. General Hospital in Building 14. You can also go to CPEP on your own. CPEP is open 24 hours a day, 7 days a week. When the Mobile Crisis Unit is not available, the Access Helpline can work with you during the emergency and can contact your service provider or 911, if necessary.

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C. Housing Options

If you are enrolled with the D.C. Department of Mental Health, you may have access to a number of housing options. Your caseworker should work with you to decide what type of housing setting you prefer. Your housing choice should become a part of your treatment plan, so there should be housing goals with timelines. You may be eligible for some of the following housing programs:

- Home First
- Bridge Subsidy
- Single Room Occupancies (SROs)
- Community Residential Facilities (CRFs)

Community Residential Facilities (CRFs): CRFs are supervised group homes that are certified and licensed by the D.C. Department of Mental Health. Your case worker must submit proof that you need assistance with medication supervision in order for you to qualify for a CRF. To pay for the CRF, your SSI or SSDI check is usually supplemented by a grant called the Optional State Payment. Your case worker must submit paperwork in order for you to receive the Optional State Payment, which goes to the CRF operator. Everyone who resides in a CRF is entitled to receive at least \$100 per month, which is usually all that remains once the rent is paid. This \$100 is called the Personal Needs Allowance.

Contract CRFs: If you meet income and program requirements, you are eligible to apply for the Housing Choice waiting list and the Public Housing list at 1133 North Capitol Street, N.E. Your case worker should be able to assist you with these applications. Getting onto as many lists as possible is important so that you have the best chance of obtaining housing. To schedule an appointment, call the Client Placement Division at (202) 435-3245 between 8:30 a.m. and 4:30 p.m. If you are having difficulty obtaining assistance from your case worker, ask to speak with your CSA's housing liaison. That person has special expertise and responsibilities related to housing for clients at the agency.

Other Housing Options: Another path that may be open to you is through non-profit agencies, such as So Others Might Eat (SOME). SOME operates a number of Single Room Occupancies, as well as a number of apartment buildings. They usually require that you apply directly to the D.C. Housing Authority.

Finally, if you are 62 or older, you may apply for a unit in a senior citizen building. The D.C. Housing Authority operates some of these buildings. Others are privately operated and maintain their own waiting lists. Your case worker should be able to help you to search for these units.

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IV. INPATIENT MENTAL HEALTH SERVICES

A. Voluntary versus Involuntary Hospitalization

1. Voluntary Hospitalization

If you want to be admitted to a hospital, you can sign in as a voluntary patient. If you then decide to leave the hospital before the doctor discharges you, you'll need to ask staff for a "request for release" or discharge form. (Some hospitals call this an "AMA" form. AMA stands for "against medical advice.") Fill it out, write the date and time, sign it and give it back to staff, making sure that your written request for release gets to the doctor in charge of your unit. The doctor in charge of your unit must release you within 48 hours of receiving your written request for release.

2. Involuntary Hospitalization

Sometimes, even if you do not want to go to a hospital for mental health treatment, you can be forced to do so. This can only happen under a special set of rules, and you must have a chance to argue that you should not be held against your will. The sections below explain these rules, the facts a court considers, and when you will get a chance to argue that you should not be held against your will.

a. 48-Hour Holds

If the Mobile Crisis Team, the police or your treatment team has taken you to CPEP against your will and you don't want to stay there or be admitted to a psychiatric unit for observation, diagnosis and treatment, you can ask to be discharged. However, if the doctor at CPEP evaluates you and decides you have a mental illness and because of that illness you are a danger to yourself or others if released, then you will be held at CPEP or sent to a hospital as an emergency involuntary patient.

b. 7-Day Holds

Within 24 hours of your involuntary admission to CPEP or a hospital, if the hospital or DMH wants to keep you for more than 48 hours, the hospital or DMH must file papers in D.C. Superior Court. A court must review the papers filed by the hospital or DMH within 24 hours and either grant the request for a 7-day order or deny it. If the judge does not sign the 7-day order, you are free to leave (or to remain at the hospital as a voluntary patient). The judge makes a decision whether to extend your hospitalization for 7 days based on the papers the hospital or DMH gives to the court.

You will not be present when the judge makes the decision on the 7-day order. If the judge gives the hospital or DMH permission to hold you for 7 more days, you will be

appointed a lawyer. Your lawyer should be in touch with you during this 7-day period to find out if you want to go to court to challenge the 7-day order. A court hearing is scheduled only if you request one. The court hearing will be downtown at D.C. Superior Court and hospital staff will take you to the hearing.

c. Commitment Orders for 1 Year

If the court issues a 7-day order the hospital can, within those 7 days, file a petition (a “petition” is simply a paper filed with the court asking the court to do something) for involuntary hospitalization for up to 1 year. Usually, the treatment will be at St. Elizabeths Hospital.

If the hospital does not file a petition for involuntary commitment within 7 days, the hospital must discharge you by the end of 7th day. The hospital, as an alternative to discharge, could ask you to continue to receive treatment as a voluntary patient.

i. Hearing Before the Commission on Mental Health

DMH must notify you right away if it files a 1-year commitment petition with the D.C. Superior Court. When a commitment petition is filed, the court automatically schedules a hearing in your case. This hearing will take place at the hospital where you are being held. The hearing is before the Commission on Mental Health, which is a part of D.C. Superior Court. You should be told when the commitment hearing is scheduled.

The attorney who was appointed to represent you when the judge signed the first 7-day order will usually continue to be your attorney in the proceedings before the Commission on Mental Health. You and your attorney will be able to prepare for the commitment hearing to try to convince the Commission on Mental Health that (1) you don’t have a mental illness or that (2) even if you have been diagnosed with a mental illness, you are not a danger to yourself or others if treated in the community on a voluntary basis.

If the Commission on Mental Health makes a decision that you have a mental illness and, as a result, are likely to hurt yourself or others, then the Commission must decide whether you require commitment for inpatient treatment or outpatient treatment. If the Commission determines that you are not mentally ill or that you are not likely to be a danger, your case will be closed and you must be released right away.

ii. The Right to a Jury Trial

If the Commission on Mental Health recommends civil commitment (“involuntary hospitalization”), you have the right to a jury trial. You must decide whether you want to have a jury trial or whether you want to accept commitment for 1 year. If you want to have a jury trial, it will be scheduled a few months after your Commission hearing.

If you have a trial and are committed, you may appeal the decision to the D.C. Court of Appeals. Your lawyer should help you with this process and should continue to represent you on appeal. An appeal can take more than 1 year.

iii. What Happens if You Do Not Ask for a Jury Trial

If you decide to accept commitment, you will have to go to court a week or so after the Commission hearing and tell the judge that you do not want to have a jury trial and you agree to commitment. Your lawyer should discuss all of this with you.

The judge must order the least restrictive form of commitment possible. This means most people are committed for 1 year to receive outpatient treatment. If you are committed to inpatient treatment, you will most likely be at St. Elizabeths Hospital for up to 1 year.

d. Recommitment

About 9 months after the judge signs an order for 1-year commitment, DMH will make a decision about extending your commitment for another year. If your doctor thinks you should remain committed (as an outpatient or an inpatient) for another year, the government will file papers in court. The papers filed in court are a “petition for recommitment” and a certificate from your doctor stating why the doctor believes you have a mental illness and are dangerous to yourself or others, as a result of mental illness.

When a recommitment petition is filed in court, a hearing before the Commission on Mental Health will be scheduled to take place about 4 to 6 weeks later. A lawyer, probably your original lawyer, will be appointed to represent you. A copy of the recommitment petition will be sent to you and to your lawyer. At the hearing, the government must prove by clear and convincing evidence that you continue to have a mental illness and, because of that mental illness, you are dangerous to yourself or others.

If the Commission agrees with the government, the Commission will extend your commitment for a 1-year period. There is no limit on how many times your commitment may be extended. You do not have a right to a trial after the Commission on Mental Health orders recommitment.

The commitment or recommitment order requires DMH and all other mental health care providers to treat you in the least restrictive appropriate setting possible. Your attorney can advocate for you to be treated in a less restrictive setting than St. Elizabeths.

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B. Seclusion and Restraint

Whether you are in the hospital voluntarily or by court order, hospitals can only use seclusion or restraint, including chemical restraint, in an emergency. Only hospitals and mental health crisis programs can use seclusion and restraint. A “restraint” is anything the staff does to prevent you from moving the way you want to, including mechanical restraints, handcuffs, or medication that is used to control your behavior. “Seclusion” is whenever you are kept in a room away from other patients, and the staff locks the door, prevents you from leaving the room, or makes you believe you are not free to leave the room.

Before a hospital or crisis program is allowed to use seclusion or restraint against you or give you medication to control your behavior, the attending physician on your ward must sign a statement saying that the seclusion or restraint was medically necessary to prevent you from injuring yourself or another person. You must present an imminent threat of hurting yourself or another person. The doctor must state that there was no other way available at the time to prevent the harm, or that all other possible ways to prevent the harm were tried and did not work. If it is an emergency and the physician or physician’s assistant is not present, a registered nurse (RN) can put you in restraints or seclusion before a written order is obtained. However, if a verbal order is not received within 15 minutes, you must be released. Also, if the doctor does not see you face-to-face within an hour, you must be released.

TIP → D.C. law forbids treatment staff from using seclusion and restraint for more than 24 hours, and your doctor has to review the order and write a new one every 4 hours if you’re an adult.

Seclusion and restraint cannot be used:

- to coerce you into doing something you don’t want to do;
- to discipline you for breaking a hospital or unit rule;
- when it’s just for staff convenience; or
- by staff in retaliation against you for complaining or for filing a grievance.

When staff put you in seclusion or restraint, they have to stop using it as soon as you calm down. You should never be in restraints or kept in the seclusion room when you are calm or sleeping. Finally, restraint and seclusion should never be used at the same time.

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C. Discharge Planning

By law, discharge planning should begin as soon as you enter an inpatient setting and should be part of your treatment plan.

If you are connected to a CSA, you should have a community support worker who helps you find a place to live in the community, get a job, find a day program, and apply for whatever public benefits you are entitled to. In the Resources section on page 20-25, there are a number of peer advocacy groups and advocacy organizations that can help you in the discharge planning process.

Notes: _____

V. CONCLUSION

We hope this book helps you to understand what your rights are and how you can stand up for yourself to make sure your rights are respected.

This book is meant to be used as a source of information about the rights of consumers who get their mental health services in the District of Columbia, not as legal advice. To get specific legal advice about your mental health services and your rights, you may call University Legal Services and explain your situation. ULS will give you the legal advice you need for your particular issue or refer you to other organizations that can.

VI. RESOURCES

A. DMH-Certified Core Services Agencies (CSAs)

Anchor Mental Health	202-635-5900	1001 Lawrence Street, NE, WDC 20017
Community Action Group	202-373-0655	3325 13 th Street, SE, WDC 20020
Community Connections	202-546-1512	801 Pennsylvania Ave, SE, WDC 20003
Family & Child Services of WDC	202-543-0387	509 16 th Street, NW, WDC 20003
Family Preservation	202-543-0387	810 Potomac Ave., SE, Ste 107, WDC 20003
Fihankra Place, Inc.	202-547-8450	810 Potomac Ave., SE, WDC 20003
First Home Care Corp.	202-737-2554	1012 14 th Street, NW, WDC 20005
Green Door	202-464-9200	1221 Taylor Street, NW, WDC 20011
Launch, Inc.	202-291-0951	6865 Eastern Ave., NE, Ste 211, WDC 20012
Life Stride, Inc.	202-635-2320	3005 Bladensburg Rd., NE, Lower Level Suite C, WDC 20018
Mary's Center	202-737-6191	1313 New York Ave., NW, WDC 20005
Neighbors Consejo (English & Spanish)	202-234-6855	3118 16 th Street, NW, WDC 20019
Progressive Life	202-349-8900	1933 Montana Ave, NE, WDC 20002
PSI	202-547-3870	770 M Street, SE, WDC 20003
Psychiatric Center Chartered	202-635-3577	3001 Bladensburg Road, NE, WDC 20018
RCI DC Counseling Center	202-581-6328	2526 Pennsylvania Ave., SE, WDC 20020
Scruples Corp.	202-581-2455	2811 Pennsylvania Ave., SE, WDC 20020
Universal Healthcare Management Services, Inc. English, Spanish, Amer. Sign Language	202-583-1181	3230 Pennsylvania Ave., SE, WDC
Volunteers of America Chesapeake	202-223-9630	1330 New Hampshire Ave., NW, WDC 20036
Washington Hospital Center	202-877-6333	216 Michigan Ave., NE, WDC 20017

B. Community Resources

Christ House

1717 Columbia Road, NW
Washington, DC
202-328-1100
www.christhouse.org

24-hour medical recovery facility providing residential healthcare for individuals who are homeless and sick

Unity Health Care, Inc.

3020 14th Street, NW
Washington, DC
202-745-4300
www.unityhealthcare.org

Comprehensive multi-specialty healthcare

Whitman-Walker Clinic

1407 S Street, NW
Washington, DC
202-797-3500
www.wwc.org

Clinic providing healthcare for individuals with HIV/AIDS

Bread for the City

1525 7th Street, NW
Washington, DC
202-265-2400 –and–
1640 Good Hope Road, SE
Washington, DC
202-561-8587
www.breadforthecity.org

Food pantry, clothing, legal and social services, medical clinic

Community Council for the Homeless

At Friendship Place
4713 Wisconsin Ave, NW
Washington, DC
202-364-1419
www.cchfp.org

Housing, medical and psychiatric care, substance abuse and job counseling

Bethany Women's Center

1333 N Street, NW
Washington, DC
202-939-2060
www.nstreetvillage.org

Services for homeless/very low-income women. (Food, shelter, showers, clothing, mental and physical health-care.)

Father McKenna Center

19 Eye Street, NW
Washington, DC
202-842-1112

Meets the immediate needs of the poor and the homeless

Friendship House

619 D Street, SE

Consumer goods and services

Washington, DC
202-675-9050
www.friendshiphouse.net

Georgetown Ministry Center
1041 Wisconsin Ave. NW
Washington, DC
202-338-8301
www.georgetownministrycenter.org

Laundry, counseling,
psychiatric care

Martha's Table
2114 14th Street, NW
Washington, DC
202-328-6608
www.marthastable.org

Child/Family services, dinner,
clothing, recreation, education

Rachel's Women's Center
1222 11th Street, NW
Washington, DC
202-682-1005
www.ccdsd.org/howorwc.php

Hygiene, laundry, lunch,
phone, mail, clothing, social events

Sasha Bruce Youthwork
741 8th Street, SE
Washington, DC
202-675-9340
www.sashabruce.org

Counseling, housing, family
services

So Others Might Eat (SOME)
71 "O" Street, NW
Washington, DC
202-797-8806
www.some.org

Lunch, medical and dental,
job and housing counseling

Unity Health Care
Re-Entry Health Center
1604 Morris Road, SE
Washington, DC
202-715-1600
Hours: 7:30 am -4:30 pm

Emergency transitional
housing, employment
placement, life skills,
job training, education,
clothing, for D.C. residents
returning from jail/prison

Academy of Hope GED Center
601 Edgewood Street, NE
Washington, DC
202-269-6623
www.aohdc.org

Education to empower
adults who lack education
due to poverty

C. Legal Assistance

Employment Discrimination

ACLU/NCA

202-457-0800

DC Employment Justice Center

202- 828-9675

Legal Counsel for the Elderly (60+)

202-434-2170

Neighborhood Legal Services

202-269-5100

Washington Lawyers' Committee for
Civil Rights & Urban Affairs

202-319-1000

U.D.C. School of Law HIV/Public
Entitlements Clinic

202-274-7312

Whitman-Walker Clinic

202-939-7627

Housing Issues

Archdiocesan Legal Network

202-772-4324

Legal Aid Society of DC

202-628-1161

Legal Counsel for the Elderly (60+)

202-434-2170

Neighborhood Legal Services

202-269-5100

Washington Lawyers' Committee for
Civil Rights and Urban Affairs

202-319-1000

Landlord Tenant Issues

Archdiocesan Legal Network

202-772-4324

Bread for the City Legal Clinic

202-265-2400

DC Law Students in Court

202-638-4798

George Washington University
Community Legal Clinics

202-994-7463

Legal Aid Society of DC

202-628-1161

Legal Counsel for the Elderly (60+)

202-434-2170

Bankruptcy

Archdiocesan Legal Network

202-772-4324

202-434-2170

Legal Counsel for the Elderly (60+)

Bread for the City Legal Clinic

202-265-2400

DC Law Students in Court

202-638-4798

Consumer Issues

Archdiocesan Legal Network

202-772-4324

DC Law Students in Court

202-638-4798

Legal Counsel for the Elderly (60+)

202-434-2170

Multi-Door Dispute Resolution Division,

DC Superior Court

202-879-1540

Neighborhood Legal Services

202-269-5100

Divorce

Archdiocesan Legal Network

202-772-4324

George Washington University

Community Legal Clinics

202-994-7463

Neighborhood Legal Service

202-269-5100

Child Support, Alimony

Archdiocesan Legal Network

202-772-4324

Bread for the City Legal Clinic

202-265-2400

George Washington University

Community Legal Clinics

202-994-7463

Legal Aid Society of DC

202-628-1161

Neighborhood Legal Services

202-269-5100

Multi-Door Dispute Resolution Division,

DC Superior Court

202-879-1540

Child Custody

Archdiocesan Legal Network

202-772-4324

Neighborhood Legal Services

202-269-5100

George Washington University

Community Legal Clinics

202-994-7463

Multi-door Dispute Resolution Division,
DC Superior Court
202-879-1540

Legal Aid Society of DC
202-628-1161

Public Benefits

Archdiocesan Legal Network
202- 772-4324

Legal Aid Society of DC
202-628-1161

Bread for the City Legal Clinic
202-265-2400

Neighborhood Legal Services
202-269-5100

George Washington University
Community Legal Clinics
202-994-7463

Guardianship

Archdiocesan Legal Network
202-772-4324

Legal Aid Society of DC
202-628-1161

George Washington University
Community Legal Clinics
202-994-7463

Legal Counsel for the Elderly
202-434-2170 (60 or over)

Mental Health Advocacy Organizations

University Legal Services
202-547-0198

Consumer Action Network
202-842-001

Consumer Leadership Forum
202-553-5153 / 202-737-6191

VII. FORMS

A. FAIR Form B Consent to Representation in a Grievance

FAIR	District of Columbia Department of Mental Health Consumer Grievance Procedure Form B Consent to Representation	B
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Information Received by (Name)		FAIR Case No.	
Consumer's First Name	Middle Initial	Consumer's Last Name	
Representative's First Name		Representative's Last Name	
Representative's Address 1		Representative's Address 2	
City	State	Zip	Telephone
Email Address		Preferred Method of Contacting Representative (Circle)	
		TELEPHONE WRITE EMAIL DONT CONTACT	
Relationship to Consumer (Circle One)			
FAMILY FRIEND IND. PEER ADVOCATE OTHER PEER ADV. STAFF ULS OTHER			
<p><input type="checkbox"/> I agree to allow _____ to represent me in filing this grievance and to act as my personal representative for purposes of the privacy laws.</p> <p><input type="checkbox"/> I want him or her to be notified of everything that happens to my grievance.</p>			
Signature of Consumer _____		Date _____	
<input type="checkbox"/> Consumer would not sign form. Reason: _____			
Please give consumer a copy of this form and staple it to Form A: New Grievance			

- To the Consumer:**
1. A copy of this form is proof that you filed your grievance on the date above. Please keep your copy of the form until your grievance is over.
 2. Information about your grievance that you provide, or that others provide, may be shared with staff of the Office of Consumer and Family Affairs and with others who respond to the grievance. Information about the grievance will NOT be placed in your clinical record or shared with anyone not involved in the grievance.
 3. You cannot be punished or treated unfairly because you file a grievance.

Revised 12.31.03

B. FAIR Form C Consumer Form for Filing a Grievance

FAIR	District of Columbia Department of Mental Health Consumer Grievance Procedure Form C Consumer's Form for Filing a Grievance	C
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Please print. Look at BOTH SIDES. Fill out the numbered sections. If you have questions about the form, see your provider's peer advocate or FAIR representative, or call the Independent Peer Advocate Program at 202-544-3600, or call the FAIR program toll-free at 1-866-866-6602.

Date		Received By		FAIR ID
1. Today's Date		2. Name of your provider		3. Your Date of Birth
4. Your First Name	5. Middle Init.	6. Your Last Name		7. <input type="checkbox"/> Male <input type="checkbox"/> Female
8. Your Address				
9. City	10. State	11. Zip Code	12. Email Address	
13. Your Main Telephone Number		14. Can someone leave a message for you there? <input type="checkbox"/> Yes <input type="checkbox"/> No		
15. Another Telephone Number for You?		16. Can someone leave a message for you there? <input type="checkbox"/> Yes <input type="checkbox"/> No		
17. How do you prefer to be contacted? <input type="checkbox"/> TELEPHONE <input type="checkbox"/> WRITE <input type="checkbox"/> EMAIL <input type="checkbox"/> IN PERSON			18. Do you have a problem with a specific person? If so, please write their name:	
19. Please tell us about your grievance (use another sheet of paper if you need to):				
20. What do you want done about the problem (use another sheet of paper if you need to)?				
21. If you have tried to solve this problem before, please tell how and what happened:				

Form C Revised 3.1.04

Please see the other side ▶

C. FAIR Form E Decision to Appeal

FAIR	District of Columbia Department of Mental Health Consumer Grievance Procedure Form E Decision to Appeal	E
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Information Received by (Name)		Name of Consumer	
FAIR ID No.	Date of Appeal (Usually Today's Date)	Date of Last Response to Grievance	
Appeal will be to:			
<input type="checkbox"/> Provider Executive <input type="checkbox"/> Department of Mental Health—External Review <input type="checkbox"/> Director of DMH			
<p>1. I have decided to appeal my grievance. I understand that I will receive a response to my appeal no later than <input style="width: 150px; height: 20px;" type="text"/></p> <p>2. If I am appealing to External Review:</p> <ul style="list-style-type: none"> <input checked="" type="radio"/> I ___ am ___ am not willing to meet in the same room with provider staff to discuss the grievance. <input checked="" type="radio"/> I prefer (select one) ___ mediation, ___ a hearing, ___ no preference (please note that the FAIR program will make the final decision). <input checked="" type="radio"/> I need the following special accommodation: _____ 			
Signature of Consumer _____		Date _____	
<i>Please provide a copy of this form to the consumer</i>			

D. Psychiatric Advance Directive

(Declaration of Advance Instructions for Mental Health Treatment)

I, **(consumer's name)** _____ **(sometimes referred to as the "principal")**, being of sound mind, voluntarily create these advance instructions for mental health treatment to assure that my choices will be carried out if I am unable to make my own decisions.

By this document, I intend to create a declaration of advance instructions for mental health treatment as authorized by District of Columbia law, to indicate my wishes regarding mental health treatment. To the extent, if any, that this document is not valid under District of Columbia law, it is my desire that it be considered a statement of my wishes and that it be given the greatest possible legal weight and respect. I understand that this directive will only be used when I cannot make my own mental health treatment decisions.

Even if I left blanks on the form or did not complete certain sections, I want all completed sections to be followed. If I have not expressed a choice, then whoever is appointed as my substitute decision maker should make the decision that he or she thinks is the decision I would make if I were able to do so.

It is my intention that each part of my advance instructions for mental health treatment stand alone. If some parts are invalid under District of Columbia law or ineffective, I desire that all other parts be followed, by whoever is appointed as my substitute decision maker.

I intend this declaration of advance instructions for mental health treatment take precedence over any and all living will and/or durable power of attorney for health care documents and/or other advance directives I have previously executed that addresses mental health treatment, to the extent that they are inconsistent with this document.

A. STATEMENT OF SPECIAL PROVISIONS AND LIMITATIONS REGARDING HEALTH CARE FOR MENTAL ILLNESS

1. Alternatives to hospitalization.

- 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 would prefer to receive this care in:

_____ a program/facility designed as an alternative to psychiatric hospitalization.

OR

_____ a psychiatric hospital.

- In the event I am to be admitted to a program/facility or a hospital for 24-hour care, I

would prefer to receive care at one of the following:

- I would prefer NOT to be admitted to the following:

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

2. *My decisions regarding emergency interventions.*

I understand that, if I am an imminent danger to myself or others, my choices or directives need not be followed by the health professionals. However, if it is determined that an emergency intervention is required (for example, seclusion or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be used are as follows:

- I prefer these interventions in the following order:

(Fill in numbers, giving 1 to your first choice, 2 to your second choice, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well.)

- _____ Seclusion
- _____ Physical restraints
- _____ Seclusion and physical restraint (combined)
- _____ Medication by injection
- _____ Medication in pill form
- _____ Liquid medication
- _____ Other: _____

- My reasons:

3. *My preferences about the physicians who will treat me if I am hospitalized.*

- My choice of treating physician is:

Dr. _____ OR

Dr. _____ OR

Dr. _____

- I do **not** wish to be treated by the following, for the reasons stated:

Dr. _____, Reason: _____

Dr. _____, Reason: _____

Dr. _____, Reason: _____

4. My decisions regarding medications for psychiatric treatment.

(In this section, you may choose any of the paragraphs that you wish to apply. Be sure to initial those you choose.)

a. _____ I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with the reservations, if any, described herein.

b. I consent to the following medications:

_____ I request my agent to seek and consent to the administration of the latest and most advanced medication unless it conflicts with my choice as set forth in paragraphs (c) and (d) below.

_____ I consent to and authorize my agent to consent to the administration of:

Medication Name: _____.

Not to exceed the following dosage: _____

OR In such dosage(s) as determined by the following physicians: _____

Medication Name: _____.

Not to exceed the following dosage: _____

OR In such dosage(s) as determined by the following physicians: _____

c. _____ I consent to the medications deemed appropriate by Dr. _____.

d. _____ I specifically **do not** consent and I **do not** authorize my agent to consent to the administration of the following medications or their respective brand-name, trade-name or generic equivalents:

Medication Name: _____

Reason for Refusal: _____

e. _____ I am willing to take the medications excluded in (d) above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

f. _____ I have the following other instructions about psychiatric medications:

5. ***Other instructions about mental health care.***

- Instructions regarding approaches that help me when I'm having a hard time.

(Check any of the following options that you would want to happen. You can also write in your own instruction in your words on the lines below the "other" box at the end of the list.)

If I am having a hard time, the following approaches have been helpful in the past. I would like staff to try these approaches with me:

- | | | |
|---|---|---|
| <input type="checkbox"/> Voluntary time out in my room | <input type="checkbox"/> Listening to music | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Voluntary time out in quiet room | <input type="checkbox"/> Calling my therapist | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Talking to my psychiatrist | <input type="checkbox"/> Punching a pillow | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Talking with a peer | <input type="checkbox"/> Pacing the floor | <input type="checkbox"/> Pounding clay |
| <input type="checkbox"/> Sitting near Staff | <input type="checkbox"/> Talking with staff | <input type="checkbox"/> Calling a friend |
| <input type="checkbox"/> Deep breathing exercises | <input type="checkbox"/> Writing in a journal | <input type="checkbox"/> Adjusting diet |
| <input type="checkbox"/> Having cool water available | <input type="checkbox"/> Having my hand held | <input type="checkbox"/> Lying down |

- Taking a shower/bath Medication as needed Going for a walk
- Being with certain people/not being with certain people (specify): _____
- Other (specify): _____

Instructions regarding actions that are *not* helpful.

(Check any of the following options that you would NOT want to happen. You can also write in your own instruction in your words on the lines below the "other" box at the end of the list.)

In the past, I have found that the following actions make me feel worse:

- Exposing my situation to others Seclusion Restraints
- Being touched Lying down Talking with peer(s)
- Sitting near staff Being held Loud talking
- Writing in journal Loud noises Crowds/crowding
- Being compared to others Other (specify): _____

• Special instructions regarding touch/body space considerations.

(Check any of the following options that you would want to happen. You can also write in your own instruction in your words on the lines below the "other" box at the end of the list.)

- I do not want to be touched
- I want to be asked permission before being touched
- I want to be told reasons why I am being touched
- I want special attention to be given to allowing me extra personal body space
- Other: _____

• My reasons:

Use this space to add any other instructions you wish to have followed:

B. STATEMENT OF MY DECISIONS REGARDING NOTIFICATION OF OTHERS, VISITORS, AND CUSTODY OF MY CHILD(REN)

1. Who should be notified immediately of my admission to a psychiatric facility?

If incompetent, I desire staff to notify the following individuals immediately that I have been admitted to a psychiatric facility:

Name	Relationship	Address	Phone (Day)	Phone (Eve)	Permission To Visit Me
					Yes _____ No _____
					Yes _____ No _____
					Yes _____ No _____

2. Whom do I authorize to receive information when I'm in crisis or hospitalized?

If incompetent, I desire that the following persons to receive information about my status/care:

Name	Relationship	Address	Phone (Day)	Phone (Eve)	Permission To Visit Me
					Yes _____ No _____
					Yes _____ No _____
					Yes _____ No _____

3. *Who should be prohibited from visiting me?*

I do not wish the following people to visit me while I am receiving care in a psychiatric facility:

Name	Relationship

In the event that I am unable to care for my child(ren), pursuant to D.C. Code § 16-4803, I have executed a written designation for a standby guardian to care for my child(ren).

If you are interested in designating a standby guardian for your child(ren), please contact ULS for assistance.

C. SIGNATURE OF PRINCIPAL (CONSUMER) AND WITNESSES.

By my signature I indicate that I, or my legal guardian if I am under the age of 18, understand the purpose and effect of this document.

I sign my name to this declaration of advance instructions for mental health on: _____,
20____(date)

at: _____
(address)

(consumer's signature) (print consumer's name)

(legal guardian's signature) (print legal guardian's name)

WITNESSES

I am at least eighteen (18) years of age, I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this declaration of advance instructions for mental health treatment in my presence, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not the principal (consumer), nor am I a health care provider or an employee of the health care provider from which the principal receives services.

First Witness

Second Witness

Signature: _____ Signature: _____

Print Name: _____ Print Name: _____

Home Address: _____ Home Address: _____

Date: _____ Date: _____

AT LEAST 1 OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION:

I further declare that I am not related to the principal by blood, marriage or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal under a currently existing will or by operation of law.

Signature: _____ Date: _____

Print Name: _____

District of Columbia Statutory Power of Attorney

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO BY NOTIFYING THE PERSON YOU DESIGNATED AS YOUR ATTORNEY-IN-FACT EITHER VERBALLY OR IN WRITING. UNLESS YOU DIRECT OTHERWISE, THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED ORALLY OR IN WRITING.

I, _____, residing at _____

hereby appoint _____, who resides at _____

as my agent (attorney-in-fact) to act for me in any lawful way with respect to the following subjects that I have initialed:

_____ (A) Property rental and lease agreements, including reporting, re-certification and annual lease renewal procedures as required.

_____ (B) Banking and other financial transactions. My attorney-in-fact will serve as my representative payee for my (initial all that apply):

_____ Social Security benefits (including death benefits, retirement benefits, Supplemental Security Income (SSI), and/or Social Security Disability Income (SSDI))

_____ Pension benefits

_____ Other

(explain) _____

From my benefits, my attorney-in-fact will give me money to cover my living expenses. My attorney-in-fact will handle my banking by depositing and withdrawing money in my name.

S/he will pay all my bills in a timely manner and assure that sufficient money is available to purchase food and supplies to maintain my home and allow me to enjoy myself to the extent my income will permit after my bills are paid.

_____ (C) Insurance transactions (Medical, Property (Homeowner or Renter), Auto, Life)

_____ (D) Local, State and Federal Individual and Property Taxes

_____ (E) Claims and/or litigation on my behalf

_____ (F) Application, documentation requirements, recertification and renewal procedures

required to secure and maintain benefits from the Social Security Administration, DC Medicaid, DC Department of Health Care Finance, DC Income Maintenance Administration and other governmental agencies.

_____ (G) Services provided through the DC Department of Health Care Finance and the DC Department on Disability Services and its contractor-provider agencies. I am able to communicate what I like and dislike about the activities and service providers that work with me.

(H) I prefer to receive services and supports (initial one):

_____ in my own home (or apartment)

_____ in a group home

_____ in an intermediate care facility

_____ in a nursing home.

I authorize my attorney in fact to participate in discussions with me and my providers to advocate on my behalf to ensure that the services meet my needs.

_____ (I) Health care decisions about particular treatments or services that I am unable to make on my own due to incapacity. If that is the case, my attorney-in-fact will have the power to grant, refuse, or withdraw consent on my behalf for the specific health care services, treatment or procedures that I need help with. My attorney-in-fact also has the authority to talk with health care personnel, access and disclose medical information about me and sign forms necessary to carry out these decisions.

I authorize all health care providers to release and I give consent to the use and disclosure of health information about me for treatment and advocacy purposes.

My attorney-in-fact may serve as my personal representative for the purposes of the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, I specifically authorize my attorney-in-fact (as my personal representative) to request, receive, and review any information regarding my physical and/or mental health, including my medical records from physicians, hospitals, or outpatient clinics, and/or any records relating to the services and/or care provided by or through the DC Department on Disability Services, among other agencies.

I further authorize my attorney-in-fact (as my personal representative) to execute on my behalf any authorizations, releases, or other documents that may be required to obtain the information described above to implement the health care decisions that s/he is authorized to make under this document.

A more specific description of my preferences for health care is included in a separate Advance Medical Directive that I have signed.

In the event that I become incapacitated for a prolonged time period and this Durable Power of Attorney, and my Advance Medical Directive are not sufficient to address all my needs, it may become necessary for a court to appoint a guardian or a conservator for me. If that is the case, I nominate my attorney-in-fact or the alternate attorney-in-fact designated below to serve as my guardian or conservator, only with respect to my needs that are not addressed in the Power of Attorney and my Advance Medical Directive.

In the event that the attorney-in-fact named above becomes incapacitated or is, for any reason, unable or unwilling to be my attorney-in-fact, I hereby appoint as my alternate attorney-in-fact:

_____, who resides at _____ to act for me regarding the subjects initialed and described above.

My attorney(s) in fact will serve without any compensation, except for reimbursement for out-of-pocket expenses spent while acting on my behalf.

THIS POWER OF ATTORNEY WILL CONTINUE TO BE EFFECTIVE EVEN IF I BECOME INCAPACITATED OR DEEMED INCOMPETENT BY A COURT OF LAW.

I AGREE THAT ANY THIRD PARTY WHO RECEIVES A FULLY EXECUTED DUPLICATE COPY OF THIS DOCUMENT MAY ACT UNDER IT. REVOCATION OF THE POWER OF ATTORNEY IS NOT EFFECTIVE AS TO A THIRD PARTY UNTIL THE THIRD PARTY LEARNS OF THE REVOCATION EITHER ORALLY OR IN WRITING. I AGREE TO INDEMNIFY THE THIRD PARTY FOR ANY CLAIMS THAT ARISE AGAINST THE THIRD PARTY BECAUSE OF RELIANCE ON THIS POWER OF ATTORNEY.

I have signed and delivered to my attorney-in-fact and my alternate attorney-in-fact this power of attorney on this _____ day of _____, 20__.

By my signature, I state that I understand the purpose and effect of this document.

(Signature)

(Print)

(Social Security No.)

(Date of Birth)

(Address)

(Telephone)

WITNESSES:

I declare that I personally know the person(s) who signed this document below in my presence and that they appear to be of sound mind and under no duress, fraud or undue influence. Also, these people are not the person(s) I appointed as my attorney(s)-in-fact by this document, nor are they my health care provider or employees of my health care provider.

First Witness: _____
(Signature)

First Witness: _____
(Print Name)

First Witness: _____
(Home Address, Telephone No.)

First Witness: _____
(Date)

Second Witness: _____
(Signature)

Second Witness: _____
(Print Name)

Second Witness: _____
(Home Address, Telephone No.)

Second Witness: _____

(Date)

AT LEAST ONE OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION:

I further declare that I am not related to _____ by blood, marriage or adoption. To my knowledge, I am not entitled to any part of his/her estate.

Signature: _____

Print name: _____

DISTRICT OF COLUMBIA) SS:

I, _____, a Notary Public, within and for the District of Columbia, do hereby certify that the foregoing Durable Power of Attorney was brought to me in the District of Columbia by _____ and was executed and acknowledged by him/her to be a free and voluntary act.

Subscribed and sworn to before me this _____ day of _____, 20__.

(Notary Signature)

My Commission Expires: _____

VIII. GLOSSARY

Attorney in Fact – Someone named to make legal decisions on behalf of another individual. This authority should be supported by a written Power of Attorney document.

Commission on Mental Health – A panel appointed by the D.C. Superior Court to hear cases about civil inpatient and outpatient commitment. It is made up of one judge, one psychiatrist, and one psychologist.

Comprehensive Psychiatric Emergency Program (CPEP) - A program that operates 24 hours a day and 7 days a week to provide emergency psychiatric services, mobile crisis services and extended observation beds for individuals over the age of 18.

Conservatorship – When an individual cannot manage his or her assets and finances, a legal right is given to another person to be responsible and have control of the individuals' assets and finances. It is established by a court order.

Core Service Agency (CSA) – A private provider certified by the D.C. Department of Mental Health to provide mental health services. The services provided by a CSA may include: medication management, case management, diagnostics and assessments.

External Review – Is one step in the consumer grievance process. After receiving a written response regarding the grievance, the consumer has the opportunity to disagree with the response. There are two types of external reviews: mediation and hearing. In mediation, an external reviewer (someone outside DMH) works with all parties to come to a solution. In a hearing, the external reviewer listens to all parties involved and writes a report to the Director of the Department of Mental Health.

Grievance – A complaint filed with a mental health provider or the Department of Mental Health if a consumer is dissatisfied with his/her mental health care or if he/she feels his/her rights have been violated.

Guardian – A person who has the legal authority to make decisions on behalf of another individual, the ward. A guardian is usually put in place when the ward is unable to make legal decisions for himself/herself. Guardians are court appointed and required to submit reports periodically to the court about the status of the ward. Sometimes the court puts limits on a guardian's power, but other times the guardian has very broad decision-making power. There are some things a guardian can never control unless a court specifically says they can, such as whether or not you should get married or have children.

Incompetent – A term to describe when an individual is unable to adequately manage his or her affairs. If an individual is unable to manage his or her affairs, a legal guardian can be appointed.

Individual Recovery Plan (IRP) - A guide to help an individual recover by using the individual's strengths, preferences, experiences and background. The plan is created by

the individual and others close to that person, usually the treatment team. It is often called a treatment plan.

Informed Consent – Agreeing to a medical procedure or medication when the individual has a clear understanding of the possible consequences or side effects. If an individual has a guardian, the guardian must give the consent, not the individual.

Involuntary Commitment – Placing an individual in a psychiatric hospital against his/her will. If the stay is longer than 48 hours, it must be issued by a court order.

Medication Review Officer – A neutral person, appointed by a provider or the Department of Mental Health, who reviews the need for involuntary medication.

Mobile Crisis Team – Responds to adults in the District of Columbia who are experiencing a psychiatric crisis and are unable or unwilling to travel to receive mental health services. The team provides crisis stabilization, including dispensing medication and performing assessment for voluntary and involuntary hospitalizations and linkages to other services, such as crisis beds and substance abuse detoxification and treatment. The team works with family members and the community-based mental health provider, if appropriate, to help with follow up.

Power of Attorney – A person assigned to act on someone’s behalf in a legal matter.

Psychiatric Advance Directive (PAD) – A legal document that expresses the consumer’s preferences for treatment to be used in the future if the consumer is involuntarily committed or unable to give or withhold informed consent.

Representative Payee - Social Security's Representative Payment Program provides financial management for the Social Security and SSI payments of beneficiaries who are incapable of managing their benefits.

Restraint – When an individual is prevented from moving and can include: Mechanical Restraints – items like handcuffs or leg cuffs that prevent an individual from being able to move his/her arms and legs; Chemical Restraints – any medication used to control behavior during an emergency. “Chemical restraints” can include any drug given without consent when an individual is in crisis, such as medications given with a needle; Physical Holds – any time a staff member uses force to stop an individual from moving, without using any item or medication to control him/her.

Seclusion – When an individual is placed in a room alone and not allowed to leave. It is seclusion even if the door to the room is open if the individual is not allowed to leave.

Treatment Team – A group of people that help create your plan for treatment and recovery. The team is multidisciplinary and includes doctors, social workers, advocates, and others who are close to the consumer.