

Mental Health Advance Directives

Effective Implementation Workgroup Recommendations

Second Substitute Senate Bill 5660; Section 1(4); Chapter 374; Laws of 2024

December 1, 2025

Executive summary

[Second Substitute Senate Bill 5660 \(2024\)](#) directed the Health Care Authority (HCA) to convene a work group to develop recommendations for the effective implementation of Mental Health Advance Directives (MHADs). A MHAD is a legal tool that enables individuals with mental or behavioral health conditions to document their treatment preferences before a crisis occurs. This work group was directed by 2SSB 5660 and with recommendations from HCA and the contractor to reflect the diversity of individuals who use and access MHADs and behavioral health services.

Two subgroups were also identified by the legislature to make recommendations:

- 1) **Document storage subgroup:** to recommend a reliable, standardized, and accessible method for MHAD creation, storage, and sharing so that individuals, families, agencies, and providers can discover and use mental health advance directives when they are needed.
- 2) **Training for document creation and utilization subgroup:** to create MHAD document creation and utilization trainings to support utilization by individuals with lived experience, families, agencies, and providers.

The recommendations report and the trainings were developed within the subgroups and presented and reviewed within the larger workgroup. The subgroups drafted their respective documents during work sessions and were encouraged to review the documents and develop recommendations independently to be reviewed at the work sessions.

Recommendations

The attached report, produced by Health Management Associates (HMA), presents the final recommendations set forth by this workgroup. Additional strategies for achieving the workgroup's recommendations are also in HMA's report. The work group emphasizes that successful implementation will require ongoing collaboration, community-led education, and a phased approach that centers equity and continuous improvement.

1. **Trust and engagement:** Prioritize the individual's control of their own MHAD, who can access it, and what is shared. Providing education and training that involves community partners is essential to increase knowledge, trust, and utilization.
2. **Access, privacy, and security:** The system should prioritize equitable access for diverse populations. Easy and quick access while maintaining privacy and security. Include role-based and secure access based on defined user criteria.
3. **Interoperability and enterprise strategy:** Have a single unified repository for all types of advanced planning documents used to inform care when an individual is unable to make those decisions themselves. The repository should seamlessly share information between systems and providers, and ensure information is accessible when needed.

4. **Quality and improvement:** Pilot a repository focused on essential features and has flexibility to improve as it grows. Maintain a person-centered approach to design and incorporate mechanisms for collecting feedback with ongoing improvements.

Seven next steps are recommended to meet the recommendations of the report.

1. **Align cross-agency efforts:** a central repository needs to be able to integrate multiple types of advance planning documents and connect across agencies and partners.
2. **Engage system partners, people with lived experience, and diverse communities:** it is imperative to engage a range of system partners, people with lived experience, and diverse communities throughout the process to develop and implement a MHAD repository.
3. **Define system requirements:** work is needed by agencies to further plan and define system technical and functional requirements aligned with the work group's recommendations.
4. **Leverage existing Washington technologies and determine gaps:** the work group emphasizes the importance of reusing and leveraging current investments, technologies, and tools in use by state agencies and community partners.
5. **Determine cost estimates:** identify potential options for the development of the MHAD repository and the costs associated with it.
6. **Develop training and engagement plan:** training will need to be made available for individuals who will create MHADs and those who will need to have access to them. Training should be prioritized even before the repository is completed to help facilitate the immediate utilization of MHADs.
7. **Build a phased-approach timeline:** follow a phased approach that will meet the recommendations in the report and incorporate what was learned from the previous phase implementation.

Contact

Division of Behavioral Health and Recovery
P.O. Box 45531
Olympia, WA 98504-2704
Phone: (844) 284-2148
hca.wa.gov

*Washington Mental Health Advance Directive
Effective Implementation Work Group
Recommendations*

AS DIRECTED BY SECOND SUBSTITUTE SENATE BILL 5660; SECTION 1(4);
CHAPTER 374; LAWS OF 2024

DECEMBER 1, 2025

FINAL REPORT

Table of Contents

Executive Summary	5
Background	7
Work Group Recommendations	10
Implementation Path Forward	14
Training Toolkit and Promotion of MHAD Utilization	18
Conclusion	20
Appendixes	21
Appendix A. Work Group and Subgroup Members	21
Appendix B. MHAD Training Toolkit Topics	24
Appendix C. Summary of Tribal Considerations for MHAD Repository and MHAD Training	26
Appendix D. Summary of Tribal Priorities Integrated Throughout Report.....	28

List of Acronyms Used in This Report

Acronym	Definition
ACP	Advance Care Planning
ADs	Advance Directives
AI/AN	American Indian or Alaska Native
AIHC	American Indian Health Commission
APIs	Application Programming Interfaces
ASL	American Sign Language
BH	Behavioral Health
BH-ASO	Behavioral Health Administrative Services Organization
DOH	Washington State Department of Health
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Services
ePCR	Electronic Patient Care Report
FHIR	Fast Healthcare Interoperability Resources (widely used HL7 standard for representing and exchanging health information; federally mandated)
HB	House Bill
HCA	Washington State Health Care Authority
HIE	Health Information Exchange
HL7	Health Level 7 (standards organization that develops practical guides to express the International Patient Summary using FHIR)
HMA	Health Management Associates
IHCP	Indian Health Care Provider
IPS	International Patient Summary
MHAD	Mental Health Advance Directive
PACIO	Post-Acute Care Interoperability
PADs	Psychiatric Advance Directives
POLST	Portable Orders for Life-Sustaining Treatment (sometimes referred to as “Physician,” “Provider,” or “Medical” instead of “Portable”)
RCW	Revised Code of Washington
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SUD	Substance Use Disorder
TCBHAB	Tribal Centric Behavioral Health Advisory Board
UW	University of Washington
WSMA	Washington State Medical Association
2SLGBTQIA+	Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual, + (other gender identities)

Acknowledgements

The successful completion of this report would not have been possible without the collaboration and support of numerous individuals and organizations. We extend our deepest appreciation to the members of the Mental Health Advance Directive Effective Implementation Work Group and the Document Repository and Training Subgroups, whose strategic guidance, lived experience, professional insights, and generous contributions of time were instrumental throughout the project. State agency representatives from the Washington State Health Care Authority, Washington State Department of Health, and Washington Department of Social and Health Services provided important understanding of current state agency efforts and existing technologies relating to development of recommendations for a centralized Mental Health Advance Directive repository and training toolkit. We also acknowledge the contributions of partners beyond Washington State—from California, North Carolina, Oregon, Virginia, and West Virginia—who shared key learnings from their experiences developing document repositories and MHAD training materials. Finally, we recognize the dedication of partners whose commitment and expertise have been integral to the quality and success of this report: Todd and Laura Crooks with Chad’s Legacy Project; Meredith Grigg with the Northwest Justice Project; the Lived Experience Collaborative; the Tribal 988 Subcommittee/Tribal Centric Behavioral Health Advisory Board; Dakota Steel and HCA’s Office of Community Empowerment Advisory Council; Paul Nagle-McNaughton and the Comprehensive Healthcare staff; and Ralph Casillas with the staff and members of Washington Clubhouses.

Executive Summary

Background

Mental Health Advance Directives (MHADs) are legal tools that allow individuals to document their preferences for mental health treatment in advance of a crisis. These directives empower individuals to maintain autonomy over their care during periods of incapacity, typically including both treatment instructions and the designation of a mental health agent to make decisions on their behalf.

Washington State has recognized MHADs since 2003 and is among more than 25 states with laws supporting their use. Despite this long-standing legal framework, MHADs remain underutilized due to persistent barriers such as limited public awareness, lack of provider training, the absence of a centralized system for storing and accessing MHADs, and other barriers. To address these challenges, the Washington State Legislature passed **Senate Bill (SB 5660)** in 2024, establishing the **MHAD Effective Implementation Work Group and Subgroups**. The Work Group and Subgroups were tasked with developing recommendations to support the creation of a statewide MHAD repository and a comprehensive Training Toolkit to promote MHAD utilization.

The Work Group and Subgroups included over 50 members representing a range of system partners, including individuals with lived experience, state agencies, healthcare and behavioral health providers, emergency responders, legal and technology experts, peer advocates, and other system partners. Tribal perspectives were further integrated through engagement with the **Tribal 988/Tribal Centric Behavioral Health Advisory Board**.

Recommendations

This report presents the Work Group’s final recommendations to the governor and legislature. The Work Group’s recommendations are grounded in a shared commitment to person-centered care, equity, and systemwide collaboration. They address long-standing impediments to MHAD utilization—such as lack of awareness, limited infrastructure, and challenges in access—while leveraging Washington’s existing investments in health information technology (IT) and improvements to the behavioral health crisis response system.

Organized into **four core domains—Trust and Engagement; Access, Privacy and Security; Interoperability and Enterprise Strategy; and Quality and Improvement**—the Work Group’s **eight recommendations** offer a road map for building a centralized MHAD repository and promoting widespread use of MHADs. The Work Group underscores the need for **sustainable funding to advance these recommendations**, which can build upon and leverage existing state investments.

Domain	Recommendation
Trust and Engagement	1. The repository should be designed in a way that prioritizes and allows individuals to own and control their MHAD, determining who may access it and what information is shared.
	2. Community education and training efforts will be essential to increase general knowledge, trust, and utilization of MHADs and an

	MHAD repository among individuals, families, Tribal partners, care providers, crisis responders, and diverse system partners.
Access, Privacy, and Security	3. The system should prioritize equitable access for diverse populations in its design and implementation.
	4. The system should support easy, quick access for authorized users while maintaining the privacy and security of information, including role-based and secure access to MHADs for individuals and system partners based on defined user criteria.
Interoperability and Enterprise Strategy	5. Establish a single, unified repository for all types of advanced planning documents used to inform care that a person receives when unable to make decisions independently.
	6. Allow bidirectional connectivity to support broad access and sharing of standardized MHADs. Ensure integration and interoperability with a range of current Washington State systems.
Quality and Improvement	7. Engage an MHAD pilot focused on the initial repository with essential features as a starting point, and flexibility to improve as it grows.
	8. Engage users, providers, and other partners in a person-centered approach to designing the repository. Incorporate mechanisms for collecting feedback from both users and providers and commit to an ongoing process of system improvement.

Implementation Path Forward

Successful implementation of a centralized MHAD repository will require strategic coordination across state agencies and system partners. The Work Group emphasizes the importance of leveraging Washington’s existing technologies and infrastructure to maximize impact while minimizing costs. The Work Group offers clear, actionable steps—including defining system requirements, engaging partners, and estimating costs—that can guide the state toward effective deployment.

The Work Group also underscores that technology alone is not sufficient. Building awareness, trust, and adoption of MHADs will depend on robust community education and training. The Work Group’s **MHAD Training Toolkit** offers a practical resource to support individuals, families, and providers in understanding and completing MHADs.

As the legislature evaluates future investments needed, the Work Group emphasizes actions needed to advance recommendations outlined in this report with a specific focus on:

- Investing in the further development of an MHAD Repository, as outlined by the Work Group recommendations, and
- Investing in the promotion of MHAD trainings and a community awareness campaign to support broader awareness and utilization of MHADs across Washington communities. This should include expansion of the MHAD Training Toolkit, such as support for professionally produced video vignettes that demonstrate partner roles and use of MHADs.

Background

Legislative Charge and Purpose

In 2024, the Washington State Legislature passed **Senate Bill 5660 (SB 5660)**,¹ recognizing the need to strengthen the implementation and utilization of Mental Health Advance Directives (MHADs) across the state. MHADs are legal documents that allow individuals to express their preferences for mental health treatment in advance of a crisis, including the designation of a trusted agent to make decisions on their behalf during periods of incapacity.

SB 5660 established the **Mental Health Advance Directive Effective Implementation Work Group**, supported by two specialized **Subgroups**, to develop recommendations for improving MHAD utilization. The Work Group was specifically tasked with:

- Providing recommendations on the development of a **statewide MHAD repository** to support secure storage and access, and
- Creating an **MHAD Training Toolkit** to promote awareness, understanding, and use of MHADs by individuals, families, providers, and system partners.

This report serves as the Work Group's final deliverable to the governor and legislature, due December 1, 2025. The MHAD Training Toolkit is available on the Washington State Health Care Authority (HCA) MHAD [webpage](#).

What Are Mental Health Advance Directives?

An **MHAD** is a legal tool that enables individuals with mental or behavioral health conditions to document their treatment preferences before a crisis occurs. MHADs typically include:

1. **Advance Instructions:** Specific preferences for medications, hospitalization, therapies, and other treatment modalities
2. **Mental Health Power of Attorney:** Designation of an agent authorized to make decisions on the individual's behalf during periods of incapacity

MHADs are rooted in principles of autonomy, dignity, and person-centered care. They offer people a proactive means of guiding their treatment, reduce trauma during crises, and improve coordination among providers, responders, and a person's designated agent.

Historical Context and Current Challenges

Washington State has recognized MHADs since 2003, when legislation was enacted to establish their legal standing. Today, Washington is one of more than 25 states with laws supporting MHADs. Despite this legal foundation, MHADs remain underutilized due to several persistent barriers:

- **Limited Awareness:** Many individuals, families, and providers are unaware of MHADs or unsure how to complete and use them.

¹ State of Washington 68th Legislature. Second Substitute Senate Bill 5660. Mental Health Advance Directive Effective Implementation Work Group. Effective June 6, 2024. Available at: <https://lawfilesexternal.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5660-S2.SL.pdf?q=20250305092529>.

- **Lack of Infrastructure:** Without a centralized system for storing and retrieving MHADs, it can be difficult for providers and responders to access the directives during emergencies.
- **Complexity of Completion:** Individuals often require assistance to complete MHADs, and many lack access to trained facilitators or legal guidance.
- **Equity Gaps:** Populations such as Tribal communities, rural residents, people with disabilities, and individuals with limited English proficiency face additional barriers to MHAD access and use.

MHAD Work Group and Subgroups Structure

To address these challenges, SB 5660 charged the MHAD Effective Implementation Work Group, with input from two complementary Subgroups, to develop recommendations for the effective implementation of MHADs (see [Figure A](#)). Specifically, the Subgroups include:

- **The Document Storage Subgroup:** Charged with recommending a reliable, standardized, and accessible method for MHAD document creation, storage, and sharing so that individuals, families, agencies, and providers can discover and use MHADs when needed. This Subgroup is responsible for developing recommendations on the following:
 - A path to creation of a statewide MHAD repository
 - Next steps toward piloting or implementation
 - How to approach interoperability with other public and private systems such as the 988 crisis line, electronic health records (EHR), and the community information exchanges
 - Reasonable steps necessary to protect the privacy of the individual
- **The Training for Document Creation and Utilization Subgroup (Training Subgroup):** Charged with developing MHAD trainings to support creation and utilization of MHADs by individuals with lived experience, families, agencies, and providers. This Subgroup addressed:
 - Partner engagement on training topics of document creation and utilization
 - Development of training toolkits rooted in best practices for recovery and peer support
 - Designation or development of a hosting location for the toolkit within the authority
 - Recommended best practices for creation and completion, access, and use of MHADs
 - Program testing and data collection of training toolkits and engagement strategies at two pilot locations—one in eastern Washington and one in western Washington

Figure A. MHAD Work Group and Subgroup Structure

Mental Health Advance Directive Effective Implementation Work Group	
Role: Develop recommendations for the effective implementation of MHADs in Washington	
Document Storage Subgroup Role: Inform the recommendations on a reliable, standardized, and accessible method for MHAD document creation, storage, and sharing	Training for Document Creation and Utilization Subgroup Role: Develop and pilot a Training Toolkit regarding MHAD document creation and utilization

Work Group and Subgroup Membership

The Work Group and Subgroups were composed of over 50 members representing diverse groups outlined in SB 5660, including (see [Appendix A](#)):

- Behavioral health providers
- Crisis response providers
- First responders and emergency services
- Hospitals and healthcare providers
- Individuals and families with lived experience
- Legal and technology experts
- Peer advocates and support organizations
- State agencies
- Chad’s legacy project
- Other system partners

The Work Group and each Subgroup included **at least five members with lived experience** and additional members contributing lived experience combined with professional expertise. In alignment with HCA policy, lived experience representatives were offered compensation for their time and contributions. The Training Toolkit was piloted with Washington Clubhouses to gather feedback directly from people with lived experience. The Lived Experience Collaborative also provided input to inform the training topics and ensure their relevance.

In addition, the Work Group engaged Tribal partner input and perspectives throughout its work through the **Tribal 988/Tribal Centric Behavioral Health Advisory Board**. [Appendixes C and D](#) include a summary of Tribal input integrated throughout the Work Group recommendations and the MHAD Training Toolkit.

Work Group Recommendations

The Mental Health Advance Directive Effective Implementation Work Group was convened to develop actionable recommendations that support the creation, storage, and use of MHADs across Washington State. These recommendations reflect the collective expertise and lived experience of more than 50 members, including individuals and families impacted by behavioral health crises, state agencies, healthcare and behavioral health providers, crisis responders, Tribal partners, legal and technology experts, and peer advocates.

The Work Group’s recommendations are grounded in a shared commitment to person-centered care, equity, and systemwide collaboration. They address long-standing barriers to MHAD utilization—such as lack of awareness, limited infrastructure, and challenges in accessing during a behavioral health crisis—while leveraging Washington’s existing investments in health IT and behavioral health reform.

The Work Group identified **eight recommendations within four core domains**: trust and engagement, access, privacy and security, interoperability and enterprise strategy, and quality and improvement. These recommendations offer a road map for building a centralized MHAD repository and promoting widespread adoption and meaningful use of MHADs in Washington. The Work Group underscores the need for sustainable funding to advance these recommendations, which can build upon and leverage existing state investments to maximize efficiencies.

Recommendations

I. Trust and Engagement

Establishing trust with individuals and Washington communities is foundational to the development of a successful MHAD repository that individuals, families, providers, Tribes, first responders, and other system partners can use and rely on. Individuals should feel empowered and informed about how the system works, including privacy and legal considerations. An MHAD repository must provide confidence that an individual’s mental health information will be handled with care, that the information will be disclosed in accordance with their wishes, and that those who engage with them during care or in crises will respect their needs.

1. Involvement of the individual in directing their care is a central aspect of MHADs. **The repository should be designed in a way that prioritizes and allows individuals to own and control their MHAD**, determining who can access it and what information is shared.
2. **Community education and training efforts will be essential to increase general knowledge, trust, and utilization of MHADs and an MHAD repository** among individuals, families, Tribal partners, care providers, crisis responders, and diverse system partners. These efforts should be community-led, tailored to diverse community and culturally specific needs, and build on existing community education efforts such as health fairs and workshops. Tribal partners emphasized the importance of building relationships and trust with Tribal communities to overcome the history of mistrust of providers and state systems.

For the MHAD system to be seen as viable and useful, there needs to be sufficient adoption of advance directives by individuals. Likewise, it is imperative that providers, first responders,

Recommendations

individuals and families understand the purpose of MHADs and adopt practices to honor an individual's care preferences as expressed in these documents to the extent appropriate and possible. In the *Implementation Path Forward* section of this report, the Work Group highlights the opportunity for development of an **MHAD community awareness campaign** as well as the need for **promotion of the MHAD Training Toolkit** and additional training resources to increase understanding and use of MHADs across Washington.

II. Access, Privacy, and Security

The system should promote creation of MHADs among diverse populations and ensure that MHADs are accessible to authorized users when needed. It is important that mental health information is available to the necessary parties such as first responders or healthcare providers, but also that it remains secure to respect the dignity and privacy of the individual.

3. The system should **prioritize equitable access for diverse populations in the design and implementation**, including:

- a. Addressing the needs of diverse populations, including but not limited to Tribal communities, rural and agricultural communities, individuals with intellectual and/or developmental disabilities, 2SLGBTQIA+ populations, people with substance use disorder, youth, and communities of color.
- b. Supporting multilingual and plain language design.
- c. Recognizing mistrust of the system by communities that have experienced discrimination and historical injustices.
- d. Exploring the need for allowing both paper and digital submissions to ensure individuals have equitable access to create, submit, and update their MHADs.
- e. Considering strategies to ensure both individual and authorized user access to stored MHADs in rural areas, including those with limited internet connectivity.
- f. Providing resources that support low-income and diverse populations' ability to understand and complete MHAD forms. Examples include creation of a helpline or identification of facilitators to assist individuals with completion of MHAD forms consistent with research showing that structured assistance can increase the number of individuals with MHADs.²

4. The **system should support easy, quick access for authorized users while maintaining the privacy and security of information. Key elements include:**

- a. Enable individuals to complete and submit the MHAD with the support of providers and other authorized individuals, as needed.
- b. Enable role-based and secure access to MHADs for individuals, individual representatives, providers, first responders, and law enforcement based on defined user criteria. This includes the ability for the individual to limit access to MHAD information for certain types of users,

² Swanson JW, Swartz MS, Elbogen EB, Kim M. Facilitated Psychiatric Advance Directives: A Randomized Trial of an Intervention to Foster Advance Treatment Planning among Persons with Severe Mental Illness. *Am J Psychiatry*. 2006;163(11):1943–1951. doi: 10.1176/ajp.2006.163.11.1943

Recommendations

such as first responders to just the elements appropriate for their role, as well as offering varied and appropriate permissions for others such as viewing, editing, or voiding directives.

- c. Ensure that Tribal data are protected and managed under Tribal data sovereignty principles. See similar efforts to address Tribal data sovereignty through Washington’s 988 technology platform. In addition, build opt-in/opt-out mechanisms for both individuals and programs regarding data sharing with non-Tribal entities.
- d. Align with the Washington IT Security policy and standards ([Securing IT Assets](#)) and state agency standards in areas such as system privacy and security, quality, user-experience, access controls, role-based permissions, and other areas. Key system features identified by the Work Group that should be addressed include but are not limited to:
 - Ensure appropriate and sufficient information is submitted to establish unique identity verification for individuals creating and submitting MHADs (e.g., driver’s license, address, date of birth, etc.)
 - Allow individual-matching algorithms for accuracy in identifying and linking individual records through the Washington Human Services Enterprise Coalition [Master Person Index](#)
 - Establish role-based access controls and permissions linked to identity verification and authentication
 - Ensure appropriate levels of user authentication when logging in; allow single sign on with appropriate credentials
 - Allow individuals to restrict or grant access to certain parties or share only specific parts of the MHAD
 - Provide interoperable consent forms through [ConsentLink](#), HCA’s Electronic Consent Management platform
 - Use robust, secure data encryption protocols and standards
 - Provide secure, encrypted cloud-based storage
 - Include validation of document completeness (e.g., signature) and legal compliance before document acceptance, as well as processes for document correction and updates
 - Ensure document version control (track edits and updates to directives)
 - Enable EHR vendors to query MHADs directly from the repository via standards-based APIs (application programming interfaces) or embedded links
 - Support the backloading of current repository data into the new or updated system
 - Provide robust search functionality (e.g., by name, date of birth, medical record number, other demographic data, etc.) for those users whose roles allow them to search the repository
 - Ensure multilingual support and plain language design for public access
 - Provide end-to-end encryption, regular vulnerability scans, and intrusion detection systems/audit logging capabilities to monitor access

Recommendations

III. Interoperability and Enterprise Strategy

The repository should seamlessly exchange information between systems and providers and ensure information is accessible when needed.

5. **Establish a single unified repository for MHADs along with other types of advance care planning documents.** The storage and access to documents such as MHADs should align with a repository for Portable Orders for Life Sustaining Treatments (POLST) and other advance care planning documents, allowing individuals and authorized users to access through a centralized system rather than navigating multiple systems for different document types. Advance care planning documents that could be stored and accessed through a centralized system may include, for example, MHADs, POLST, durable power of attorney for health care (DPOA-HC), durable power of attorney for finance (DPOA-F), supported decision-making agreements, crisis support plans, living wills, less restrictive alternative court orders, personal advance care plans, advance directives for living with dementia, and other documents.
6. **Allow bidirectional connectivity to support broad access and sharing of standardized MHADs.** Leverage data interoperability based on HL7 Fast Healthcare Interoperability Resource (FHIR) international standards. Ensure integration and standards-based interoperability with the following systems:
 - a. Washington Health Information Exchange, [Health Commons Project OneHealthPort](#)
 - b. Washington 988 Crisis Response Platform (in development)
 - c. Emergency medical service (EMS) systems
 - d. Electronic Health Record systems
 - e. Healthcare Enforcement and Licensing Management System ([HELMS](#)) to authenticate licensed providers accessing the system
 - f. [ConsentLink](#), Washington HCA’s electronic consent management system
 - g. Washington Health and Life Event System ([WHALES](#)) vital records system
 - h. Washington Health and Human Services Enterprise Coalition [Master Person Index](#)
 - i. Tribal providers and systems, including Indian Health Care Providers and Tribal crisis response and first responder systems

IV. Quality and Improvement

The MHAD repository should be designed and refined based on feedback from individuals and providers to improve repository performance, adoption, and individual care outcomes.

7. **Conduct an MHAD pilot that focuses on an initial repository with essential features as a starting point, and flexibility to improve as it grows.** Applying the concept of “don’t let perfect be the enemy of good,” start with a pilot project and collect feedback from system users and providers to inform ongoing improvements.
8. **Engage users, providers, and other partners in a person-centered approach to designing the repository** and applications/strategies to access the repository. Incorporate mechanisms for collecting feedback from both users and providers and commit to an **ongoing process of system improvement.**

Implementation Path Forward

In recognition of the current state budget environment, the Work Group sets forth the implementation path below as an approach to leveraging existing state investments to promote MHAD utilization and develop a statewide MHAD repository. Each step outlined below highlights core actions needed, which may occur in parallel and are not intended as a linear sequencing of actions needed.

- 1. Align Cross-Agency Efforts:** The MHAD Work Group recognizes that the path toward development and implementation of a central repository for MHADs starts with cross-agency collaboration and alignment of state agency efforts to develop a repository that can integrate multiple types of advance planning documents. These include, for example, MHADs, POLST, durable power of attorney for health care (DPOA-HC), durable power of attorney for finance (DPOA-F), supported decision-making agreements, crisis support plans, living wills, less restrictive alternative court orders, personal advance care plan, advance directive for living with dementia, and other documents. As part of this cross-agency work, the Work Group recognizes the Washington State Department of Health’s (DOH’s) work over the past year to explore development of a POLST repository, as directed by a 2025 legislative budget proviso. DOH provided regular updates to the MHAD Work Group on the findings and recommendations resulting from this effort, which similarly point to development of a repository that supports multiple types of advance planning documents.³
- 2. Engage System Partners, People with Lived Experience, and Diverse Communities:** The MHAD Work Group recognizes the imperative of engaging a range of system partners, people with lived experience, and diverse communities throughout the process to develop and implement an MHAD repository. The MHAD Work Group members reflect a diverse range of key partners and people with lived experience who should be included in continued work to design and implement an MHAD repository. In addition, the MHAD Work Group recognizes the importance of continued engagement with Tribal partners to further examine and address Tribal-specific considerations for an MHAD repository (see [Appendixes C and D](#)).
- 3. Define System Requirements:** Work is needed by agencies to further plan and define technical and functional system requirements aligned with the MHAD Work Group recommendations. As outlined in the Work Group Recommendations section of this report, these requirements should ensure system design that achieves the following:
 - Prioritizes and allows individuals to create, own, and control their MHAD, determining who can access it and what information is shared.
 - Supports easy, quick access for authorized users, while maintaining the privacy and security of information aligned with state and federal privacy and security standards, as well as the principle of providing access to the minimum appropriate information for the user’s needs.
 - Allows bidirectional connectivity to statewide 988, EMS, and Washington Health Information Exchange (HIE) for broad access opportunities to standardized MHADs.
 - Leverages national standards for interoperability between the repository and systems such as EHRs or patient-centered, SMART Health Link applications like WA Health Summary.

³ Washington State Department of Health. *POLST Registry Implementation Plan (June 2025)*.

- Incorporates mechanisms for collecting feedback from both users and providers and commits to an ongoing process of system improvement.
4. **Leverage Existing Washington Technologies and Determine Gaps:** Evaluate the technologies and tools Washington currently uses and identify options for leveraging these systems aligned with the MHAD repository requirements (see [Figure B](#)). This work should include examination of existing technological efforts in Washington that may be leveraged to support the development of an MHAD repository. Given the current state budget environment, the Work Group emphasized the importance of reusing and leveraging current investments. [Figure C](#) offers an example of how these technologies may support an MHAD registry; please note that this figure is provided for illustrative purposes only and does not reflect a final approach or recommendation.

Figure B. Existing Washington Technologies to Align with the Development of an MHAD Repository

Existing Washington Technologies to Align with the Development of an MHAD Repository

[Health Commons Project OneHealthPort:](#) Washington’s HIE, OneHealthPort, is a secure system that allows healthcare providers, first responders, and other agencies to share protected health information. In addition, OneHealthPort serves as the state’s [clinical data repository](#), with a master patient index and containing more than 2.4 million patient records. OneHealthPort offers an interoperability hub between EHRs and a future-state MHAD registry. The system could also be expanded to store MHADs as part of the clinical data repository.

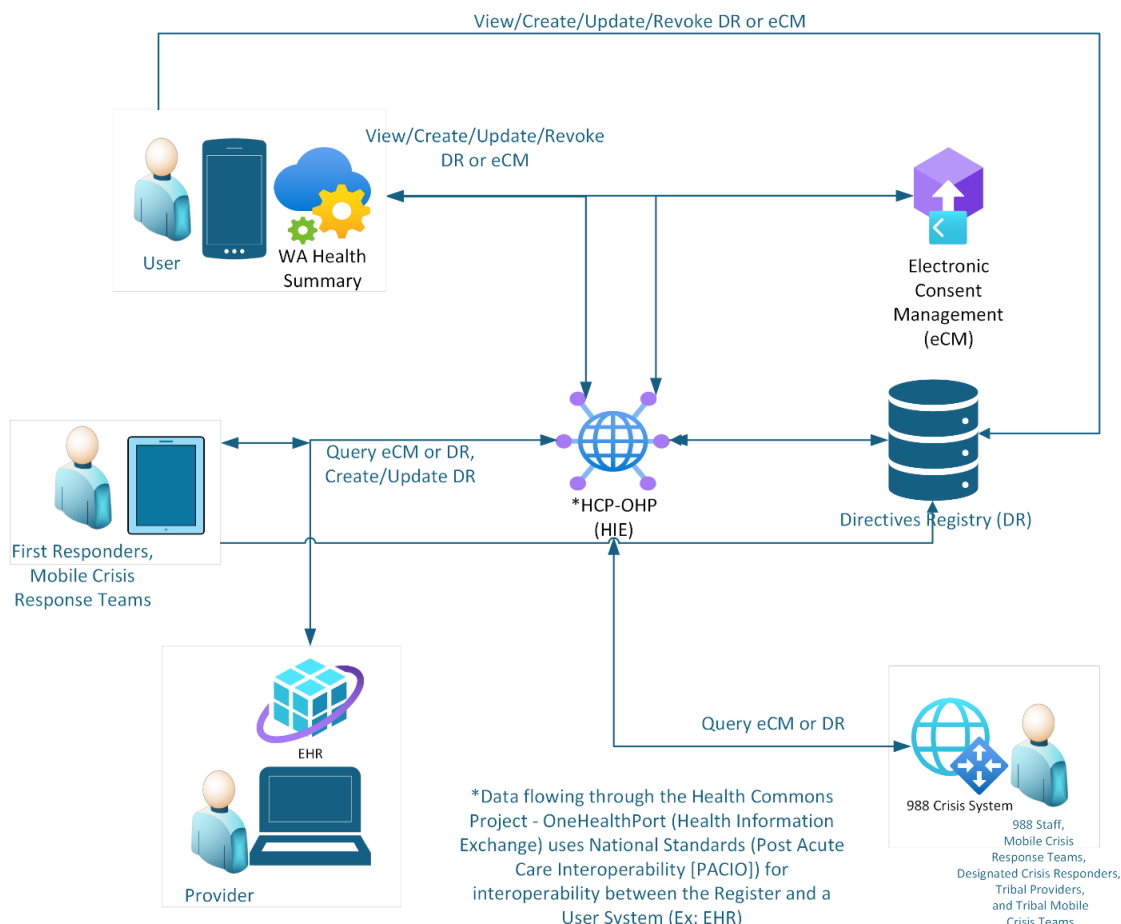
[WA Health Summary:](#) The DOH WA Health Summary application promotes empowerment of individuals to access and share their health information. The system builds on WA Verify technology, which was created to allow individuals to access DOH’s state immunization registry and electively share their COVID-19 vaccination information. WA Health Summary broadly expands the ability to share health information, including vaccinations, and allows people to access, augment, and share their personal health data using FHIR standards such as SMART Health Links and the International Patient Summary (IPS) document. To support MHADs, this system could be enhanced to allow individuals to create, store, consent to release, and electively share their MHADs.

[Washington ConsentLink:](#) Launched in 2024, Washington’s Medicaid agency is the first in the country to launch an electronic consent management system. This system centralizes and digitalizes patient consent to share sensitive health data across multiple providers in compliance with federal and state privacy and security standards, including HIPAA (Health Insurance Portability and Accountability Act) and 42 CFR Part 2 (substance use disorder). Future phases are expected to expand to Tribal services, genetic testing, advance directives, and social determinants of health. The system is available to organizations that provide services to Medicaid clients, use HIPAA and 42 CFR Part 2-compliant form, and are based in Washington.

[Washington 988 Technology Platform \(in development\):](#) As part of the state’s efforts to develop a 988 Technology platform, HCA is working to develop standardized data fields for MHADs and other types of forms to support interoperability with the 998 system.

[Post-Acute Care InterOperability \(PACIO\) Advance Healthcare Directives:](#) This initiative centers on establishing interoperability data standards based on HL7 FHIR international standards for exchanging data for MHADs and other advanced planning documents.

Figure C. Illustrative Example: Potential Approach to MHAD Repository and Interoperability with Current Washington Technologies



- 5. Determine Cost Estimates and Identify Sustainable Funding:** Based on the evaluation of existing technologies and gaps, the state should determine options for development of the MHAD repository and cost estimates associated with each. This work should also include identification of a sustainable funding source for the development and ongoing operational costs of the MHAD repository. In light of the state’s current budget environment, the MHAD Work Group underscores the opportunity to leverage and build upon the state’s existing resources and investments that can be leveraged as components of the MHAD repository as outlined in **Figures B and C**.
- 6. Develop Training Plan and Community Awareness Campaign:** For the MHAD repository to be viable and useful, it will be imperative that a sufficient volume of individuals are creating and using MHADs. This work will require significant training and engagement to support individuals to complete MHADs, as well as training for providers, crisis responders, and system partners to adopt practices to inquire if a person has an MHAD and honor an individual’s care preferences as expressed in these documents, to the extent appropriate and possible. This work can leverage and

build upon the MHAD Training Toolkit developed by the Work Group and Training Subgroup, as discussed in the *Training Toolkit* section of this report.

In addition to training, the Work Group highlighted the importance of developing a community awareness campaign to promote increased understanding and utilization of MHADs. Community awareness campaigns, such as [Friends for Life](#) (drug overdose prevention) and [Starts with One](#) (opioid misuse prevention), have served as effective tools for increasing community understanding and support for behavioral health issues and crisis prevention.

- 7. Build Phased Approach to Timeline:** The MHAD Work Group recommends that Washington pursue a phased approach that would support the state to develop and implement the MHAD repository in pilot phases with target goals and associated outcomes and learnings for each phase. For example, in Phase 1, users could create, upload, and electively share MHADs into a central repository via SMART Health Links and a web portal or web application open to any state resident. First responders and behavioral and physical healthcare providers could then access an authorized user web portal to search and identify if a person has an MHAD, and to access appropriate data. Phase 2 could focus on expansion of this technology to broader sets of users, such as caregivers and other provider types, as well as integration with EHRs and first responder digital systems. In Phase 3, the system could move toward development of an app that users may access and update via their phones. These phases are outlined here as examples only; further discussion is needed to determine appropriate goals for each phase of the MHAD repository development and implementation.

Training Toolkit and Promotion of MHAD Utilization

In recognition of the widespread lack of awareness of MHADs among healthcare and behavioral health providers, first responders, and Washington communities broadly, the *MHAD Training Toolkit* centers on establishing a foundational understanding of MHADs and promoting their utilization. The Toolkit comprises six core modules tailored to key topics and several major audiences to promote utilization.

1. Mental Health Advance Directives 101: Understanding, Supporting, Thriving
2. Compassionate Conversations: Facilitating the Completion of Mental Health Advance Directives
3. Crisis Prevention and Intervention: Leveraging the Mental Health Advance Directive
4. Agents for Mental Health Decisions: Best Practices in Supporting Mental Health Advance Directives
5. Crisis Care Providers and Mental Health Advance Directives
6. Mental Health Advance Directives and Outpatient Providers

Training Toolkit Audiences

- Persons interested in having an MHAD
- Persons facilitating completion of an MHAD
- MHAD Agents
- Persons with Lived Experience
- Family Members
- Tribal Partners
- Behavioral Health and Healthcare Professionals/Care Providers
- First Responders
- Crisis Responders and Providers
- Certified Peer Specialists/Peer Supporters

These training modules are available on the HCA MHAD [webpage](#) and described in [Appendix B](#). Each training is available as a recording that may be viewed at any time, as well as in PDF format with trainings facilitation notes to allow individuals and partners to download and engage in small group or other training settings.

Alongside the completion of the Training Toolkit and recommendations to support development of a centralized MHAD repository, Work Group members **underscored actions that can be taken in the near-term to promote increased utilization of MHADs**. These actions are not dependent on waiting for an MHAD repository to be in place and are opportunities for system partners to promote best practices to increase utilization of MHADs. Opportunities for near-term actions include, for example:

1. Distribute the *MHAD Training Toolkit* widely and maximize opportunities to promote training to increase awareness and usage of MHADs among individuals, families, crisis responders, providers, and other system partners throughout Washington.
2. Develop internal agency policies and agency-specific implementation guidance to support completion of MHADs. This work could leverage existing providers and agency requirements relating to MHADs to promote their utilization.⁴

⁴ See e.g., [WAC 246-341-0600](#) (Requiring behavioral health agencies to advise clients of their right to create an MHAD); [WAC 246-341-0420](#) (Requiring behavioral health agency personnel policies to include a description of how the agency will comply with the MHAD requirements of RCW chapter 71.32); and [WAC 182-501-0125](#) (Requiring hospitals, health maintenance organizations, and other entities to provide information to clients about executing 'advance directives'.)

3. Train system partners to serve as MHAD facilitators to support individuals with completing MHAD forms. Work Group members highlighted, for example, opportunities to train Washington peers through the Washington Peer Network to assist with the MHAD process.
4. Recognize MHAD Training as part of satisfying continuing professional education annual training requirements, such as granting Continuing Medical Education (CME) credits for completion of MHAD training modules.
5. Seek opportunities through existing community forums and health education opportunities to promote awareness of MHADs.
6. Leverage electronic health record system to support storage and retrieval of MHADs in medical records for outpatient and inpatient providers, pending availability of a centralized repository.
7. Develop guidance for providers and system partners in use of MHADs and crisis response.
8. Publish efforts to promote training and utilization of MHADs in professional journals to share learnings and best practices for increasing MHAD utilization

While the Work Group and Subgroups celebrate the completion of the Training Toolkit, members also underscored the need for additional training to build upon the foundational trainings in the Toolkit. Further opportunities identified to expand training include, for example:

➤ **Additional Areas of Focus for Trainings**

- Population-specific trainings, such as how MHADs apply when someone is incarcerated or trainings focused on cultural considerations and needs.
- Deeper areas of focus for agents, such as clarity on legal enforcement if an MHAD is not honored.
- Focus areas on specific provider types.
- Understanding how MHADs intersect with designated crisis responder evaluations.
- Development of professionally produced video vignettes that demonstrate partner roles and use of MHADs.

➤ **Training on the Completion of MHADs**

- How-to guides or annotated templates to support completion of MHADs.
- Materials and intensive trainings that help facilitators, providers, and others in enabling individuals to complete their MHADs.
- National and local technology innovations, including alternative options for storing MHADs, chatbot for clients completing an MHAD, etc.

Training Toolkit Pilot Testing

Throughout 2025, the Training Subgroup focused its efforts on the development of the MHAD Training Toolkit. Per SB 5660, the Training Subgroup also engaged program testing and data collection of the toolkit at two pilot locations, one in Eastern Washington and one in Western Washington.

The Training Subgroup identified **Comprehensive Healthcare** (Eastern Washington) and the **Washington Clubhouses** (Western Washington) as pilot sites. Comprehensive Healthcare hosted two virtual training sessions, followed by one live training session facilitated by staff. The Washington Clubhouses hosted two virtual training sessions. The pilot training sessions had a combined total of nearly 90 participants, allowing opportunity for both providers as well as individuals with lived experience to provide feedback that was integrated into the final Training Toolkit.

Conclusion

The MHAD Effective Implementation Work Group recommendations provide a path forward to developing a centralized MHAD repository and expanding the use of MHADs across Washington State. With engagement by a range of system partners, physical and behavioral health providers, individuals with lived experience, and Tribal partners, the Work Group has developed thoughtful recommendations that prioritize trust, accessibility, interoperability, and continuous improvement. These recommendations reflect a shared commitment to empowering individuals to direct their mental health care, particularly during times of crisis.

As the legislature evaluates future investments needed, the Work Group emphasizes actions needed to advance recommendations outlined in this report with a specific focus on:

- **Investing in the further development of an MHAD Repository, as outlined by the Work Group recommendations, and**
- **Investing in the promotion of MHAD trainings and a community awareness campaign to support broader awareness and utilization of MHADs across Washington communities. This should include expansion of the MHAD Training Toolkit, such as support for professionally produced video vignettes that demonstrate partner roles and use of MHADs.**

MHADs offer a proactive approach that not only enhances the quality and continuity of care, but also has the potential to transform the delivery of behavioral health and crisis response services across the state. By preventing crises and reducing reliance on acute care services, MHADs can improve health outcomes for individuals with behavioral health needs while contributing to overall system savings.

Implementation of the MHAD repository will require strategic alignment across agencies, leveraging existing technologies and infrastructure to maximize impact while minimizing costs. The Work Group's roadmap outlines actionable steps—from defining system requirements to engaging partners and estimating costs—that can guide the state toward successful deployment. By building on current investments and fostering cross-sector collaboration, Washington can lead the way in transforming mental health care planning.

The Work Group also recognizes that technology alone is not enough. Community education and training are essential to build awareness, trust, and adoption of MHADs. The Training Toolkit developed by the Work Group offers a practical resource to support individuals, families, and providers in understanding and promoting the use of MHADs.

The MHAD Work Group celebrates the progress made and the partnerships formed throughout this process. The recommendations presented in this report reflect a collective vision for promoting the use of MHADs and the development of a more responsive, person-centered behavioral health system. With continued commitment and investment, Washington has the opportunity to ensure that every individual's voice is heard and respected in their mental health care journey.

Appendixes

Appendix A. Work Group and Subgroup Members

Work Group Member	Member Representation
Brittany Weiner, Director, Opioid Stewardship and Behavioral Health, Washington State Hospital Association	Washington State Hospital Association
Chris Baumgartner, Deputy Chief Informatics Officer Washington State Department of Health	An expert in technical repositories
Dr. Chris Chen, Associate Medical Director Washington Health Care Authority	An expert in technical repositories
Christine Atienza, Clinical Director of Crisis Services Crisis Connections	988 behavioral health crisis response and suicide prevention call centers
Erin Whitney, Contracts and Compliance Volunteers of America Western Washington	988 behavioral health crisis response and suicide prevention call centers
Sara Schumacher, 988 Director Frontier Behavioral Health	988 behavioral health crisis response and suicide prevention call centers
Hillary Norris, Policy Analyst Washington State Medical Association	Washington State Medical Association
Jamie Framke, Behavioral Health Program Administrator Washington Health Care Authority	Washington Health Care Authority Behavioral Health and Recovery Division
Julie Brown, State Hospital Diversion Program Administrator, Washington Health Care Authority	Washington Health Care Authority Behavioral Health and Recovery Division
Mark Sullivan, Planning and Strategy Manager Washington Department of Veterans Affairs, Counseling and Wellness Programs	Washington Department of Veterans Affairs
Olivia Shangrow, Policy Analyst Washington Council for Behavioral Health	Washington Council for Behavioral Health
Todd Crooks, Executive Director/Co-Founder Chad's Legacy Project	Chad's Legacy Project
Chloe Merino, Staff Attorney, Treatment Facilities Program, Disability Rights Washington	Representation of Disability Rights
Anna Nepomuceno, Director of Public Policy NAMI Washington	NAMI Washington
Katy Gilbert, 911 Deputy Operations / Customer Support Supervisor, Emergency Management Division, Washington Military Department	Emergency Services Responders
Shaun Ford, Division Chief EMS Camas-Washougal Fire Department/Washington Fire Chiefs Association	Emergency Services Responders
Jennifer Piel, MD, JD, Associate Professor, Center for Mental Health, Policy, and the Law, UW Medicine	Individuals with expertise in healthcare ethics and law
Elizabeth Perry, Health Equity Consultant Equity Is. Consulting	Individuals with expertise in healthcare ethics and law
Stephanie Lane, Chief Workforce Development Officer, Peer Washington	Peer Advocacy Community

Work Group Member	Member Representation
Michelle Tinkler, Chief Advocacy Officer Office of Behavioral Health Advocacy (OBHA)	Peer Advocacy Community
Cindy Adams, Regional Peer Support Program Manager, Greater Columbia Behavioral Health Administrative Service Organization	Peer Advocacy Community
Gail Kogle, Behavioral Health Advocate, Office of Behavioral Health Advocacy (OBHA)	Peer Advocacy Community
Melissa Jackson, Co-Vice President, Board Washington Association of Designated Crisis Responders	Designated Crisis Responders
Jarrod Moran, Community Support Specialist, South Kitsap Fire CARES	Law Enforcement or Member of a Co-Responder Program
Dr. Alysha Thompson, Clinical Director & Attending Psychiatrist, Seattle Children’s	Inpatient Hospitals
Karen Thomason, Interim Director of Compliance, Frontier Behavioral Health	License or certified Behavioral Health Agency
Julia Bradley Comprehensive Health Resources	License or certified Behavioral Health Agency
Kathryn Felix, Chief Clinical Officer, Kitsap Mental Health Services	License or certified Behavioral Health Agency
Laura Crooks, Chief Executive Officer, Yakima Children’s Village	License or certified Behavioral Health Agency
Sandra Mena-Tyree, Special Projects Manager, Division of Behavioral Health and Recovery, Washington Health Care Authority	Equity representative
Maame Bassaw Representative of Lived Experience	Representation from individuals/families from diverse communities with lived experience of behavioral health crises
Von-Na Chism Representative of Lived Experience	Representation from individuals/families from diverse communities with lived experience of behavioral health crises
Elizabetha Wadsack Representative of Lived Experience	Representation from individuals/families from diverse communities with lived experience of behavioral health crises
Julia Alexandra Miriam Evans Bell Representative of Lived Experience	Representation from individuals/families from diverse communities with lived experience of behavioral health crises
Ruth Payne Representative of Lived Experience	Representation from individuals/families from diverse communities with lived experience of behavioral health crises
Ralph Casillas Representative of Lived Experience	Representation from individuals/families from diverse communities with lived experience of behavioral health crises

MHAD Document Storage Subgroup Members

1. Sriram Rajagopalan (Lived Experience Representative)
2. Kimberly Coleman (Lived Experience Representative)
3. Dakota Foxx (Lived Experience Representative)
4. Vince Wilson (Lived Experience Representative)
5. Amabel Narvaez (Lived Experience Representative)
6. Erin Whitney (Volunteers of America Western Washington)
7. Hillary Norris (Washington State Medical Association)
8. Karen Thomason (Frontier Behavioral Health)
9. Sara Schumacher (Frontier Behavioral Health)
10. Tim Curran (Crisis Connections)
11. Christal Eshelman (Carelton)
12. Ralph Casillas
13. Shaun Ford (Camas-Washougal Fire)
14. Chris Baumgartner (DOH)
15. Ravi Kafle (DOH)
16. Brittany Onye (DOH)
17. Laura Crooks (Yakima Children’s Village)
18. Todd Crooks (Chad’s Legacy Project)

MHAD Training for Document Creation and Utilization Subgroup

1. Deana Ottum (Lived Experience Representative)
2. Andrea Boyd (Lived Experience Representative)
3. Ronita Boullt (Lived Experience Representative)
4. Marcella Taylor (Lived Experience Representative)
5. Derrick Kretschmer (Lived Experience Representative)
6. Maame Bassaw (Lived Experience Representative)
7. Ruth Payne (Lived Experience Representative)
8. Brittany Weiner (Washington State Hospital Association)
9. Erin Whitney (Volunteers of America Western Washington)
10. Hillary Norris (Washington State Medical Association)
11. Holly Blondino (PeaceHealth St. John)
12. Dr. Jennifer Piel (UW Medicine)
13. Karen Thomason (Frontier Behavioral Health)
14. Katy Gilbert (State 911 Coordination Office)
15. Paul Nagle-McNaughton (Comprehensive Healthcare)
16. Tim Curran (Crisis Connections)
17. Richard VanCleave (Carelton)
18. Gail Kogle (OBHA)
19. Cindy Adams (Greater Columbia Behavioral Health BH-ASO)
20. Julia Bradley (Comprehensive Life Resources)
21. Todd Crooks (Chad’s Legacy Project)
22. John Oliver (MHAD legal expert)
23. Jarrod Moran (South Kitsap Fire CARES)

Appendix B. MHAD Training Toolkit Topics

The MHAD Training Toolkit consists of six modules, one “flash training,” and two one-pagers. Each of these trainings, the intended audiences, and time commitments are summarized below. The trainings may be accessed via the Washington HCA MHAD [webpage](#).

Training Title	Training Description
Training 1 – Mental Health Advance Directives 101: Understanding, Supporting, Thriving	This training provides an introduction to MHADs, highlighting what an MHAD is and why it matters. The training outlines the main parts of an MHAD and the basic legal rules, how to create an MHAD and what to include, what an MHAD can and cannot do, and how people can offer support in MHAD creation and use. The intended audience includes persons interested in having an MHAD, persons helping facilitate completion of an MHAD, agents, care providers, first responders, crisis providers, Tribal partners, certified peer specialists/peer supporters, persons with lived experience, and family members of persons with mental and behavioral health concerns.
Training 2 – Compassionate Conversations: Facilitating the Completion of MHADs	This training highlights key considerations for individuals to facilitate others to create an MHAD. The training addresses steps to complete an MHAD as well as ways to navigate difficult emotions and ensure the MHAD feels supportive and empowering. The intended audience includes persons interested in having an MHAD, persons helping facilitate completion of an MHAD, agents, care providers, Tribal partners, certified peer specialist/peer supporters, persons with lived experience, and family members of persons with mental and behavioral health concerns.
Training 3 – Agents for Mental Health Decisions: Best Practices in Supporting Mental Health Advance Directives	This training discusses how to choose the right person to be a mental health agent, and the role of the agent and how to support someone during a crisis, working with providers and systems, and self-care for agents. The intended audience includes persons interested in having an MHAD, agents, Tribal partners, certified peer specialist/peer supporters, persons with lived experience, and family members of persons with mental and behavioral health concerns.
Training 4 – Crisis Prevention and Intervention: Using a Mental Health Advance Directive	This training provides an overview of the role of MHADs in crisis prevention and intervention, ensuring the MHAD is used, communicating in crisis situations, and post-crisis review and MHAD revisions. The intended audience includes persons interested in having an MHAD, persons helping facilitate completion of an MHAD, agents, care providers, Tribal partners, first responders, crisis providers, certified peer specialists/peer supporters, persons with lived experience, and family members of persons with mental and behavioral health concerns.
Training 5 – Crisis Care Providers and Mental Health Advance Directives	This training provides an overview of MHADs for crisis care providers. The training addresses the role of agents and highlights how crisis responders and hospital staff can use MHADs to provide safe care that supports recovery and build trust. The intended audience includes

Training Title	Training Description
	care providers, first responders, crisis providers, Tribal partners, and certified peer specialist/peer supporters.
Training 6 – Mental Health Advance Directives and Outpatient Providers	This training provides an overview of MHADs for outpatient providers. The training highlights how outpatient providers can talk about and support MHADs, and how this can help people get better care and avoid crises. The intended audience includes persons interested in having an MHAD, care providers, Tribal partners, and certified peer specialist/peer supporters.
Flash Training – Mental Health Advance Directives 101	This flash training provides a brief introduction to MHADs, highlighting the main parts of an MHAD, what should be included in an MHAD, when an MHAD goes into effect, and steps to creating an MHAD. The intended audience includes persons interested in having an MHAD, persons helping facilitate completion of an MHAD, agents, care providers, first responders, crisis providers, Tribal partners, certified peer specialists/peer supporters, persons with lived experience, and family members of persons with mental and behavioral health concerns.
One-Pager 1 – Mental Health Advance Directives 101	This one-pager provides an introduction to MHADs, highlighting the main parts of an MHAD, who should have an MHAD, when an MHAD goes into effect, what should be included in an MHAD, legal considerations, and steps to creating an MHAD. The intended audience includes persons interested in having an MHAD, persons helping facilitate completion of an MHAD, agents, care providers, first responders, crisis providers, Tribal partners, certified peer specialists/peer supporters, persons with lived experience, and family members of persons with mental and behavioral health concerns.
One-Pager 2 – Benefits of Mental Health Advance Directives for Providers	This one-pager provides an introduction to MHADs for providers, highlighting the main parts of an MHAD, who should have an MHAD, when an MHAD goes into effect, the benefits of MHADs for providers, and the role of providers in MHAD implementation. The intended audience includes care providers, first responders, crisis providers, Tribal partners, and certified peer specialists/peer supporters.

Appendix C. Summary of Tribal Considerations for MHAD Repository and MHAD Training

Overview

The MHAD Work Group engaged Tribal partner input and perspectives through the Tribal 988/Tribal Centric Behavioral Health Advisory Board. Tribal input gathered is summarized in this Appendix and integrated throughout the Work Group Recommendations and Training Toolkit.

Trust and Engagement

- **Build Trust First:** Long-term trust-building is essential in Tribal communities; distrust of providers and systems is common.
- **Family and Elders' Role:** Respect traditional practices, such as consulting elders before decision-making.
- **Community-Led Outreach:** Leverage counselors and health fairs to share MHAD info. Let people learn and talk about MHADs in non-crisis times.
- **Buy-In vs. Admin Burden:** Frame MHADs as tools for empowerment, not more administrative work—especially for providers.

Cultural Humility and Sensitivity

- **Avoid Generalizations:** Don't assume cultural or religious norms are universal across all Tribes.
- **Respect Tribal Sovereignty:** Refer to Tribes as sovereign nations, not "stakeholders." Tailor language accordingly.
- **Cultural Relevance in Templates:** Ensure MHAD templates reflect cultural values and flexibility. Incorporate teachings, community connections, and spiritual supports.

System Integration and Training

- **Tribal Jurisdiction Education:** Non-Tribal providers need training on Tribal Sovereignty, Indian Health Care systems, and related laws.
- **Unique Tribal EMS and Crisis Responses:** Some Tribes have their own Tribal crisis response and Tribal first responder systems and training requirements, which must be respected and integrated.
- **Repository Access:** Ensure Tribal clinics/hospitals can access and use MHAD repositories with clear, inclusive language.
- **Training Distribution:** Share materials (e.g., one-pagers, logic models) in settings like health fairs and clinics.

Data Sovereignty and Privacy

- **Consent and Control:** Build opt-in/opt-out mechanisms for both individuals and programs regarding data sharing with non-Tribal entities.
- **Data Stewardship:** Clarify who stores, controls, and accesses MHADs. Protect against misuse (e.g., in child welfare or criminal justice).

- **Tribal Data Sovereignty:** Ensure that Tribal data is protected and managed under Tribal data sovereignty principles. See similar efforts to address Tribal data sovereignty through the Washington 988 technology platform.

Practical Challenges in Rural and Tribal Settings

- **Access Barriers:** Rural Tribal areas may require longer travel for care. Limited services and high provider turnover worsen the issue.
- **Continuity of Care:** Turnover impacts training continuity and awareness. Responsibility for data and system knowledge is often unclear.

Family and Individual Autonomy in MHADs

- **Flexible Definitions of Support:** MHADs should reflect extended, non-traditional support networks preferred by Tribal members.
- **Respect Individual Choice:** Providers should follow the individual's lead when determining who to include in the MHAD decision-making process (e.g., whether to include family members).
- **Living Documents:** MHADs should evolve with the individual's needs and be something they can easily revisit and understand.

Standardization and Access

- **Cultural Considerations:** The MHAD should be culturally appropriate for Tribal populations.
- **Schools and Youth Access:** Include schools (e.g., counselors) as part of MHAD access considerations.
- **Role-Based Access Planning:** Consider Tribal rights over access.

Appendix D. Summary of Tribal Priorities Integrated Throughout Report

Tribal Priorities/References Throughout Report	Page Number
Acronyms	
AI/AN American Indian or Alaska Native AIHC American Indian Health Commission IHCP Indian Health Care Provider TCBHAB Tribal Centric Behavioral Health Advisory Board	3
Acknowledgements	
Tribal 988 Subcommittee/Tribal Centric Behavioral Health Advisory Board listed.	3
Executive Summary	
The Work Group and Subgroups included over 50 members representing a wide range of system partners, including individuals with lived experience, state agencies, healthcare and behavioral health providers, emergency responders, legal and technology experts, and peer advocates. Tribal perspectives were further integrated through engagement with the Tribal 988/Tribal Centric Behavioral Health Advisory Board.	5
<i>Recommendation 2:</i> Community education and training efforts will be essential to increase general knowledge, trust, and utilization of MHADs and an MHAD repository among individuals, families, Tribal partners , care providers, crisis responders, and diverse system partners.	6
Background	
Equity Gaps – Populations such as Tribal communities , rural residents, people with disabilities, and those with limited English proficiency face additional barriers to MHAD access and use.	8
In addition, the Work Group engaged Tribal partner input and perspectives throughout its work through the Tribal 988/Tribal Centric Behavioral Health Advisory Board . Appendixes C and D includes a summary of Tribal input integrated throughout the Work Group recommendations and the MHAD Training Toolkit.	9
Recommendations	
The Mental Health Advance Directive (MHAD) Effective Implementation Work Group was convened under Senate Bill 5660 (2024) to develop actionable recommendations that support the creation, storage, and utilization of MHADs across Washington State. These recommendations reflect the collective expertise and lived experience of more than 50 members, including individuals and families impacted by behavioral health crises, state agencies, healthcare and behavioral health providers, crisis responders, Tribal partners , legal and technology experts, and peer advocates.	10
<i>Recommendation 2:</i> Community education and training efforts will be essential to increase general knowledge, trust, and utilization of MHADs and an MHAD repository among individuals, families, Tribal partners , care providers, crisis responders, and diverse system partners. These efforts should be community-led, tailored to diverse community and culturally specific needs, and build on health fairs or other community education efforts to the extent they may exist already. Tribal partners emphasized the importance of building relationships and trust with Tribal communities to overcome historic mistrust of providers and systems based on past experiences.	10

Tribal Priorities/References Throughout Report	Page Number
<p><i>Recommendation 3:</i> The system should prioritize equitable access for diverse populations in the design and implementation. This includes but is not limited to:</p> <ul style="list-style-type: none"> a. Addressing the needs of diverse populations, including but not limited to Tribal communities, rural and agricultural communities, and individuals with intellectual and/or developmental disabilities, 2SLGBTQIA+ populations, people with substance use disorder, youth, and communities of color. c. Recognizing mistrust of the system by communities that have experienced discrimination and historical injustices. 	11
<p><i>Recommendation 4c:</i> Ensure that Tribal data is protected and managed under Tribal data sovereignty principles. See similar efforts to address Tribal data sovereignty through the Washington 988 technology platform. In addition, build opt-in/opt-out mechanisms for both individuals and programs regarding data sharing with non-Tribal entities.</p>	12
<p><i>Recommendation 6:</i> Allow bidirectional connectivity to support broad access and sharing of standardized MHADs ... Ensure integration and interoperability with Tribal providers and systems, including Indian Health Care Providers and Tribal crisis response and first responder systems.</p>	13
Implementation Path Forward	
<p>Engage System Partners, People with Lived Experience, and Diverse Communities: The MHAD Work Group recognizes the imperative of engaging a range of system partners, people with lived experience, and diverse communities throughout the process to develop and implement an MHAD repository. The MHAD Work Group members reflect a diverse range of key partners and people with lived experience to be included in the path forward to design and implement an MHAD repository. In addition, the MHAD Work Group recognizes the importance of continued engagement with Tribal partners to further examine and address Tribal-specific considerations for an MHAD repository (see Appendixes C and D for Tribal-specific considerations integrated throughout the recommendations).</p>	14
Training Toolkit and Promotion of MHAD Utilization	
<p>Training Toolkit Audiences – Tribal partners listed.</p>	18
Conclusion	
<p>With engagement by a broad range of system partners, physical and behavioral health providers, individuals with lived experience, and Tribal partners, the Work Group has developed thoughtful recommendations that prioritize trust, accessibility, interoperability, and continuous improvement. These recommendations reflect a shared commitment to empowering individuals to direct their mental health care, particularly during times of crisis.</p>	20
Appendixes	
<p>Appendix C. Summary of Tribal Considerations for MHAD Repository and MHAD Training</p>	26
<p>Appendix D. Summary of Tribal References throughout Report</p>	27