

MINNESOTA ADVANCE PSYCHIATRIC DIRECTIVE AND HEALTH CARE DIRECTIVE

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The advance psychiatric directive and the health care directive are documents which set forth the current, competent choices or desires of the individual and outline the actions that may be taken by those acting on behalf of the individual and by treating personnel. The advance psychiatric directive, found under Minn. Stat. § 253B.03, applies only to treatment with neuroleptic medications and ECT (electro-convulsive therapy), so the framework for directing care is a very narrow one. The health care directive, found under Minn. Stat. Chapter 145C, is much broader in scope, allowing the appointment of a proxy, called an “agent,” to make mental and physical health care decisions as directed in the document. The health care directive may also include instructions for end-of-life decisions, often called a “Living Will.” The form included in this packet blends all three areas of decision-making into one document for you to fill out.

This information packet from the Minnesota Disability Law Center contains several items designed to help you write your own advance directive: 1) Why Should I Fill Out One of These Advance Directives?; 2) Ten Tips For Completing an Advance Directive; 3) Common Questions About Advance Directives; and 4) Minnesota Advance Psychiatric and Health Care Directives, a legal form which is a combination of both the psychiatric directive and the health care directive, and the instructions for completing it.

WHY SHOULD I FILL OUT ONE OF THESE ADVANCE DIRECTIVES? (Or, sometimes the best defense is a good offense)

An advance directive can be a powerful tool to help you maintain control over what happens to you in the hospital. An advance directive spells out what **you** want done in a time of crisis, and also enables you to choose **who** you want to make medical decisions for you. It can also let others know your plans for the care of your children, pets, or home. You can also use this document to describe those behaviors which are “indicators” of impaired capacity and which you think ought to activate the advance directive. Here are a number of important reasons why consumers/survivors should consider completing advance directives:

1. An advance directive helps you maintain **choice** and **control** in the treatment you receive, according to your knowledge of what works best for you in managing your mental health care. This includes medications and treatment you **do** and **do not** want.
2. An advance directive increases the possibility that there will be continuity of care in times of crisis, including place, type and personnel involved in treatment.
3. An advance directive may decrease the possibility of involuntary treatment.
4. If involuntary treatment does occur, a mental health care directive may have a direct impact on the treatment you do receive, including time in the hospital, the use of medications, place of treatment and treatment plan upon release.
5. Preparing a mental health care directive acts as an excellent opportunity to develop an effective crisis intervention plan and to discuss it with family, friends and consumers before the crisis arises. This includes the opportunity to discuss approaches that are effective and those that hinder rather than help in times of crisis.
6. An advance directive allows you to authorize the release of information at a time when your capacity to make authorizations is clear, and enables you to state whom you do and do not want notified at a time of hospitalization or treatment.
7. An advance directive, particularly the appointment of a proxy/agent whom you trust, can be an effective, less restrictive alternative to the court-appointment of a guardian.
8. An advance directive can include how you want your family, pets and finances cared for while you are receiving treatment.
9. The implementation of an advance directive can help restore self-confidence and allay fears and panic in a time of crisis, thus aiding in stabilization and recovery.

TEN TIPS FOR COMPLETING AN EFFECTIVE ADVANCE DIRECTIVE

1. Write your advance directive at a time when your illness is not severe enough to impair your judgment or to raise questions about the validity of the document. You probably do not want to fill out an advance directive while you are in the hospital or under commitment, unless the professionals treating you agree that your capacity is presently not impaired. If this is the case, consider asking them to witness your document!

2. Think of your directive as a relapse prevention plan or crisis intervention plan. Who do you need to be involved in your plan to make it work?

3. Sit down and discuss the directive with people you trust and who can give you good feedback about your concerns and your problems in times of crisis. Ask them what they would include in the directive if they were you. You do not have to include their suggestions, but shared wisdom may produce a stronger document, with others invested in making it work.

4. Discuss your treatment concerns, and the instructions you are thinking of putting in the directive, with those who will be involved in your treatment and care. This should include your doctor, case manager, therapist, PCA, and others directly involved in your care. **Do this before you write your directive.**

5. Discuss the contents of your advance directive with the person who will be your proxy/agent, before you finalize your directive. Can that person carry out the instructions as you wish and be a good

advocate for you? If not, can you live with whatever limitations that person may have?

6. While it is important to get the opinions, thoughts and ideas of those involved in your life and care, what goes into the directive must be decided by you, of your own free will. If you are not comfortable with the directive, if it reflects pressure from others rather than your own choices, then it is more likely that you will reject the directive at a time when you are in crisis. Therefore, family, friends and providers must be careful not to pressure you into choices that are not really yours.

7. Include your knowledge of what works for you based on your own experiences. While this is a legal document, you do not need to write it in legalese. Use your own words to describe your needs in time of crisis, what has worked and not worked for you, what has caused negative reactions or actually hindered progress. You can use a story format, but do not make it too long.

8. Read over the form until you understand it and do drafts of your directive before you actually write up your final document. Do not be afraid to ask for help, figuring out the parts you do not understand. If you fill out the directive without really understanding it, you may end up writing a directive that is not valid.

9. Think about the following things that may need to be put into your directive:

- What is the best way to describe your mental health problems?
- What triggers your crises, in particular, the point at which you would like to be

given treatment? Answering this question gives you an idea of when you want your directive to kick in.

- What are your experiences, wishes and concerns about medications and ECT?
- What are your wishes and concerns about the use of seclusion and restraints? For example, is seclusion less intrusive to you than the use of emergency medications? Are seclusion and restraint out of the question because they are contraindicated by your personal history?
- What other concerns do you have about the way you might be treated?
- What else has worked well for you in the past? Individual or group therapy? A chance to talk to someone one-to-one? Time to be alone? Regular visits from particular family or friends? Exercise or walks? Assurances that the rent is paid or your family is being cared for?
- If you are a smoker, think about how your need to smoke may be addressed. Find out what your hospital's rules are on smoking, and how your needs fit with them.
- If you want to be treated in the hospital by a particular doctor, make sure that doctor has hospital privileges. If not, you may want your doctor to recommend someone who does inpatient care at your hospital.

unreasonable instructions, you may end up raising questions about your capacity at the time you prepared your directive.

10. A directive does not give you more than what you are otherwise entitled to. Be reasonable in what you put in the directive. Do not include treatment or services you know you will not be able to get, particularly while in the hospital. Also, if your directive contains obviously

QUESTIONS AND ANSWERS ABOUT ADVANCE DIRECTIVES

1. What is an advance directive?

Most states have laws which allow competent persons to write down instructions as to the health care they wish to receive (or not receive) if they later become incapable of making such decisions. In Minnesota, the **advance psychiatric directive** and the **health care directive** enable a person to spell out his or her health care choices or desires and to outline the actions that may be taken by those acting on his or her behalf.

- The **advance psychiatric directive**, applies only to treatment with **neuroleptic medications such as Haldol or Clozaril, and ECT** (electro-convulsive therapy). **It does not apply to other mental health medications or other types of therapy.**
- The **health care directive** is much broader in scope, allowing a person to set out instructions about mental and physical health care, including decisions about the end of life.
- Both directives allow the appointment of a **proxy or an agent** to carry out a person's instructions, but do not require this.

2. When does my advance directive go into effect? How long is it in effect?

An advance directive goes into effect when you do not have the mental capacity to make an informed decision about your medical care. A decision that you lack capacity may be made by your doctors, or, if you are refusing certain treatment, by a judge. You

can state when you think your directive should go into effect by describing in your directive the behaviors which may show your capacity is becoming impaired.

- How long the directive is in effect depends on your condition. Once you regain the capacity to make informed decisions, your directive is no longer effective.
- However, the health care directive also allows you to authorize an agent to make health care decisions for you even at a time when you still have the capacity to make your own decisions.

3. How do I revoke an advance directive?

You may revoke a directive at any time **as long as you still have the mental capacity to decide to do so.** You do not need to revoke it in writing, although putting it in writing protects your decision to revoke it. **You can revoke a directive by verbally stating your intention to do so in the presence of two others, by destroying it, or by making a new one.**

- **You cannot legally revoke an advance psychiatric directive or a health care directive when you lack the mental capacity to make medical decisions.** So, you need to think carefully ahead of time about what you will put in your directive. As the saying goes, "Be careful what you wish for; you might get it."

4. What if I want to change what is in my directive?

You can write a new directive at any time, unless your capacity to make informed

medical decisions is impaired. The directive with the most recent date is generally the one that will be honored. You will want to write a new directive when you need to update treatment preferences, change proxies, name a new doctor, and so on. A good practice is to review your directive on a regular basis. We recommend once a year.

5. What happens if I refuse to go along with my directive?

If you have agreed to certain treatment in your directive but later on are refusing to go along with that treatment, several things can happen if you no longer have capacity to make decisions:

- If you have named a proxy/agent, the medical people should work with your proxy/agent to gain permission for the treatment and to get your cooperation.
- The medical people involved in your care may administer the treatment you agreed to in your directive. However, those treating you might be unwilling to follow the directive, rather than trying to force treatment on you against your will. This is a difficult ethical dilemma for medical providers, who often will defer to the courts rather than force treatment on the basis of a directive alone.
- If your situation is crucial enough, those treating you may decide to file a petition for commitment or early intervention, and may also file a petition to administer medication against your will. Decisions about capacity and treatment would then be made by a judge, who also must honor your directive unless it is not a valid one.

6. Do I have to appoint a proxy/agent? Can it be someone other than a family member?

You do not have to appoint a proxy/agent. You can make a directive limited to instructions only about your care. If you do appoint a proxy/agent, that person has the authority to act when, in the judgment of your attending physician, or a judge, you lack decision-making capacity, or when your directive authorizes the agent to act.

- **We recommend that you appoint a proxy/agent to act on your behalf for all care you are directing. The appointment of a proxy/agent to carry out your wishes means a stronger, more flexible directive** and someone who will work with the providers on your behalf at a time when you may not be able to do that very well, and can apply your wishes to new situations
- A health care provider giving you services on the day you sign the document cannot be a proxy/agent, unless related to you. Your proxy/agent should not be the owner, operator or employee of a health or residential or community care facility serving you. Otherwise, your proxy can be anyone you wish who is 18 or older, including family members, partners, and friends. The person should be someone who uses good judgment and whom you trust to carry out your wishes. **The person you name as proxy or agent cannot be a witness to your directive.**
- **If you are placed under guardianship, your guardian cannot override your appointment of an agent except under certain limited situations**, for example, your appointment of an agent was made within the last 60 days.

7. Can my case manager be a witness?

Yes, your case manager can be a witness to the signing of your advance directive. The witness is a witness to your signature and to the fact that you were of sound mind when signing the directive. Being a witness does not mean that the witness agrees with everything that is in the directive. **While a case manager can witness a directive without creating a conflict of interest, a case manager should not be a proxy or agent.** If your case manager is a witness, she or he needs to state that on the directive. However, at least one of your witnesses must be someone **not** providing care/services to you on the day you sign the document.

8. Who should have a copy of my directive? You should give a copy of your directive to those who will be involved in carrying out your instructions. In most cases, this would include your spouse/partner, proxy, doctors, case manager, and the hospital you would most likely go to. You may want others to have a copy, for example other family members or friends.

- You should be able to keep copies of your directive in your medical charts. State law requires health providers to make the directive a part of your medical record. Federal law requires your providers who are Medicare/Medical Assistance providers to document in your medical record whether or not you have an advance directive. Keep your copy in a safe place, with your other important papers.
- You may also want to carry a wallet-size Health Care Directive I.D. Card, which includes information on where your directive is kept and who your

proxy/agent is. We can provide you with this I.D. Card.

9. What if my doctor disagrees with my directive?

A doctor or other provider is obligated to follow directives that can reasonably be carried out. State law requires physicians and other providers to take all reasonable steps to comply with directives. Under both types of directives, a provider who is unwilling to comply with a directive must promptly notify the person and document this in the person's chart. In addition, an unwilling provider may transfer a person to another provider willing to provide the directed care. Providers acting in good faith reliance on a directive are immune from liability or disciplinary action, so liability concerns should not prevent your providers from honoring a reasonable directive.

10. What happens if my doctor recommends treatment that my directive does not cover?

If the doctor is recommending a course of treatment that is not discussed in your directive, the doctor may not be able to give you the recommended treatment, may have to use less desirable treatment which you are permitting, or may seek court approval to use the recommended treatment. If you have a proxy who has been given flexibility in applying your instructions, that person may be able to approve the new treatment. For example, if you have instructed your proxy to consider consenting to new neuroleptic medications not named in the directive, your proxy may be able to agree to a trial of a new medication on your behalf. This is another example of why we strongly recommend the appointment of a proxy to carry out your wishes.

11. Can I prepare a directive while I am in the hospital or under commitment?

Under the law, there is an assumption that a person is competent. Even being under a commitment does not in and of itself make a person incompetent. However, if you are court ordered to take medications, you are legally incompetent to make medication decisions, and should not fill out a directive at this time.

- **The key to filling out an advance directive is to do it when your judgment to make health care decisions is not impaired.** Depending on your condition, preparing an advance directive as part of your discharge from a hospital or as part of a provisional discharge planning process may be a timely and wise step to take.
- **If you have a case manager, one suggestion is to make completing the advance directive a goal of your individual service plan.** This goal can be worked on by you and your case manager, who can assist you in getting input from the other important people in the process, including your doctor, other care providers, and family. Making advance directive planning an ongoing service plan goal also helps you to update the directive on a regular basis.

12. How do I leave instructions about the care and custody of my children?

There are two things you can do. First, you can put instructions in your directive, including who will care for your children and any particular concerns you may have about their care. Secondly, if their other parent is not available, a “designated standby custodian” can legally take temporary custody. A “Designated Standby Custodian” form is available through our

office. You should attach it to your directive when you fill the directive out.

ADVANCE DIRECTIVES AND NEUROLEPTIC MEDICATIONS

The 2006 amendments to the Commitment Act regarding administration of neuroleptic medications affirm the important role of advance directives in the substitute decision-making process. A person who has completed a valid advance directive is in a much stronger position to have her or his wishes followed in a hospital setting, or in the court process when decisions about neuroleptic medications are being made. This handout briefly describes the new law and the use of advance directives in the area of neuroleptic medications. It does not focus on the substitute decision-making process for persons without advance directives.

1. Persons with capacity retain the right to make their own decisions about medications.

Under the law, a person with a mental illness, like anyone else, is presumed to have the capacity to make health care decisions, including decisions about neuroleptic medications. In making a determination about capacity, a court looks at **three factors**. These factors are also a guideline for consumers, doctors, and others dealing with the question of one's capacity to decide. These factors are:

- 1) Does the person **demonstrate an awareness of the situation**, including reasons for hospitalization and consequences of refusing treatment?
- 2) Does the person **demonstrate an awareness of (proposed) treatment**, including risks, benefits and alternatives?
- 3) Does the person communicate a **reasoned choice not based on delusion**, even though it may not be in his or her best interest? **Disagreement with a physician's recommendation is not evidence of an unreasonable decision.** See Minn. Stat. § 253B.092, subd. 5 (1997).

As long as you have the capacity to make decisions about health care, your advance directive does not go into effect or "activate." If your capacity becomes

impaired, the next step is for those persons treating you to determine what your directive instructs them to do.

2. What happens if you have a directive and you are not refusing neuroleptic medications?

- If your directive requests or consents to treatment with neuroleptic medications, the medications may be administered without court involvement. If your directive appoints a proxy/agent to make those decisions for you, that person may now do so, without court involvement.
- If your directive does **not** address the neuroleptic medication being proposed, for example, a new medication not available at the time you wrote the directive, **your proxy** can still consent on your behalf if the instructions to the proxy are broad enough to enable the proxy to consent under these circumstances.
- If you have not named a proxy, and proposed treatment is not covered in the directive, those treating you may not be able to honor your directive, or may have to look at the possibility of an early intervention/commitment petition to get a **substitute decision-maker** appointed. This is one reason why appointing a proxy is a good idea.

3. What happens if you have a directive and you are refusing neuroleptic medications?

- If your capacity is impaired, but you have a valid advance directive expressing your decision not to take neuroleptic medications, your directive must be honored. If you have appointed a proxy or agent to make these decisions for you, that person must do so in accordance with the instructions in your advance directive. Note that having an advance directive does not necessarily prevent a commitment petition from being filed.
- If you do not have an advance directive, or your directive does not clearly state wishes or instructions about the medication at issue, the medication cannot be given without a court order. This can only be done if you are otherwise subject to early intervention/commitment proceedings. This process involves the appointment of a substitute decision-maker.
- If your capacity is impaired, and the directive clearly consents to the medication, the care giver may administer it, or seek a court order permitting the medication.
- If you are the subject of commitment/early intervention proceedings, and have clearly stated your choice to refuse medications, the substitute decision-maker and the court must follow your wishes. Minn. Stat. § 253B.092, subd.7(b) (2006). A valid advance directive is very good evidence of your wishes when you had the capacity to make medication decisions.
- If it is an emergency, and you do not have capacity to make decisions about neuroleptic medications, the physician

may administer the medications as long as the emergency exists. Minn. Stat. § 253B.092, subd. 3 (1997). “Emergency treatment” is defined as that necessary to protect the patient or others from immediate harm. Minn. Stat. § 253B.02, subd. 6.

4. How does the substitute decision-maker process work?

- A substitute decision-maker cannot be appointed unless a **petition** for commitment or early intervention has been filed. Upon a showing that the person may lack capacity, the court shall appoint an “individual or a community or institutional panel designated by the local mental health authority” to make a decision about the use of neuroleptic medications. **The court must give preference to proxies and other agents named in directives.** Minn. Stat. § 253B.092, subd. 6 (1977).
- The substitute decision-maker, and the court, must follow the person's wishes if there is clear evidence of what the person would have done when having capacity, including refusal of neuroleptic medications. This evidence can include written documents, such as health care power of attorneys and advance psychiatric directives.
- If there is **not adequate evidence** of what the person would have done, the decision must be based on what a **reasonable person** would do, taking into consideration:
 - family, community, moral, religious, and social values;
 - medical risks, benefits, and alternatives to the proposed treatment;

- past efficacy and any extenuating circumstances of past use; and
- any other relevant factors.

Minn. Stat. § 253B.092, subd. 7(c) (2006).

- **If the person is not refusing the medications,** and the substitute decision-maker is consenting in writing to the medications, the medications may be administered. This decision, including the issue of capacity, is reviewed at the involuntary treatment hearing.
- **If the person is refusing the medications,** and the substitute decision-maker is consenting to the medications, the medications may not be administered without a court order based on the factors listed above. Minn. Stat. § 253B.092, subd. 8 (1997).
- **If the substitute decision-maker does not consent** to the medications, they cannot be given without a court order. The court must also use the factors listed above in reaching a decision. This process can be done as part of the commitment/early intervention hearing, or afterwards if the issue does not arise until later.

5. Later review

A patient subject to a court order for medications, or other person, may petition the court under Minn. Stat. § 253B.17 for review of any determination regarding the administration of neuroleptic medications, including the person's capacity to make decisions, the appointment of a substitute decision-maker, or the decision regarding

the use of neuroleptic medications. Minn. Stat. § 253B.92, subd. 10 (1997).

6. Medical records.

The changes in the law give a **physician access to “pertinent” medical records** regarding the past administration of medication without a signed authorization, unless a person retains the capacity to make decisions about record access. Minn. Stat. § 253B.0921 (1997). The authority of an advance directive which specifies access to medical records is not clearly addressed in the law. **However, an advance directive that specifies authorization of records and limitations on release, or gives a proxy the right to authorize records, may enable the individual to retain greater control over record privacy at a time of mental health crisis.**

ADVANCE DIRECTIVES AND EARLY INTERVENTION

Early intervention is a new form of involuntary treatment that is more limited than commitment. One aspect of early intervention allows the court to order treatment according to one's instructions in an advance directive. A court may order early intervention **if all of the following elements are supported by clear and convincing evidence:**

1. the person is mentally ill;
 2. the person refuses to accept appropriate mental health treatment; and
 3. the person's mental illness is manifested by instances of grossly disturbed behavior or faulty perceptions and either:
 - A. the grossly disturbed behavior or faulty perceptions significantly interfere with the person's ability to care for self and the person **when competent, would have chosen substantially similar treatment under the same circumstances; OR**
 - B. due to mental illness, the person:
 - i) has received court-ordered inpatient treatment **at least two times in the previous three years;**
 - ii is currently exhibiting symptoms or behavior **substantially similar** to those precipitating the court-ordered treatment;
 - iii) the person is reasonably expected to mentally or physically **deteriorate to the point of meeting the criteria for inpatient commitment** unless treated.
- **The pre-petition screening report** requires the screener to determine, to the extent possible, the existence of advance psychiatric declarations, health care power of attorneys, or guardian, conservator, or attorney-in-fact with authority to make health care decisions. These would be **evidence of what the person would have chosen.**
 - **The court procedures are essentially the same** as those for involuntary commitment, including right to an attorney, right to a second examiner and to present witnesses, right to a full court hearing, and right to appeal. Like commitment, the proceedings may include the issue of forced medication. The court must make specific findings of fact and conclusions of law.
 - **The court must also determine** that early intervention is **less intrusive than commitment** and that it is the **"least restrictive treatment program available** that can meet the patient's treatment needs."
 - The court may order a variety of treatment alternatives, including day treatment, medication compliance monitoring, and **short-term hospitalization not to exceed 10 days. The order shall not exceed 90 days.**
 - Statutory provisions specific to early intervention can be found at **Minn. Stat. § 253B.064 through 256B.066 (1997).**

INSTRUCTIONS

MINNESOTA ADVANCE PSYCHIATRIC AND HEALTH CARE DIRECTIVE

1. A Few Important Terms:

Proxy/Agent The psychiatric directive law uses the term “proxy” for the person you may choose to make health care decisions. The health care directive law uses the term “agent.” This document has combined the name since in many situations it will be the same person. The proxy/agent must be at least 18 years old and not a provider of your care when the document is signed or when the care is needed. If you are going to appoint an agent/proxy, discuss your wishes with him/her and be sure that person is willing to serve.

Neuroleptic Medications Neuroleptic medications are a group of medications used to treat psychoses. Common neuroleptic medications include Haldol, Prolixen, Loxitane and Stelazine. Newer, atypical neuroleptics include Risperdal, Olanzapine, Clozoril and Zyprexa. This document is written to include your instructions about neuroleptics and your instructions about other psychiatric medications, such as anti-depressants and anti-anxiety medications.

ECT (Electroconvulsive Therapy) is commonly referred to as “shock treatment.” During ECT, an electric shock is applied to the body. Side effects include short-term and longer-term memory loss. Opinions vary on the safety and effectiveness of ECT. Some people find it helpful to the treatment of severe depression. Others have great concerns about memory loss.

2. How to Fill Out the Directive:

The directive covers several areas:

- Your instructions about psychiatric medications and care;
- Your instructions about physical health care;
- Your instructions about end-of-life care;
- Your instructions about the appointment of proxy/agents; and
- Your instructions about care of your family, pets, or home. We have a separate Designated Standby Custodian form you can use to name a temporary custodian for your child/ren.

Most of the form is self-explanatory. Read through it before filling it out. Many of your questions may be answered in the section of the materials entitled “Questions and Answers About Advance Directives.”

You should do a draft of what you want to say before you fill it out. Do not write in legalese; just use your own words to say what you want to have happen.

You can attach extra pages to any section of the document, but be sure to write on the document “Additional page(s) attached.” You will need to make sure the extra page shows which section of the form it is a continuation of.

3. Making the Document Legal:

When you have completed filling out your directive, you must sign and date the directive in front of two witnesses, age 18 or older, who must also sign and date the document. It is also a good idea to initial and date each page, especially if you have attached extra pages. Only one of your witnesses can be a health care provider. Your proxy/agent cannot be a witness.

If you have filled out instructions about neuroleptic medications or ECT or appointed a proxy/agent to make decisions about these treatments, the law requires you to have two witnesses sign your directive. If you have filled out **only** the other health care portions, you can sign in front of a notary. We recommend that you sign in front of two witnesses to cover all bases.

4. Where to Keep the Completed Directive:

Keep your directive with other important papers in a safe place. Give copies of it to your doctors, the hospital you will likely use, your family and friends who will be involved in your care, and of course your proxy/agent.

We have a card you can fill out and carry that will notify others that you have a directive, how to get a copy of it, and who your agent/proxy is.

MINNESOTA ADVANCE PSYCHIATRIC AND HEALTH CARE DIRECTIVE

To My Doctors, Health Care Providers, Family and Friends:

I, _____, am a competent adult. I willfully and voluntarily make the following health care instructions, to be followed if I become incapable of making sound decisions about my health care.

I understand that I have the right to make medical, mental health, and other health care decisions for myself as long as I am capable of doing so. I understand that I have the right to revoke this document or any part of it at any time as long as I am mentally capable of doing so.

I understand that any agent or proxy appointed by me is under no legal duty to act. However, those persons appointed by me have agreed to act as my agent or proxy. It is my intention that anyone appointed by me must act consistent with my instructions as stated in this document and any wishes as otherwise made known by me.

By signing this document, I am revoking any previous advance directive or health care power of attorney that I have made.

I. INSTRUCTIONS ABOUT MY MENTAL HEALTH CARE

A. My Beliefs, Concerns and Preferences About my Mental Health Care.

I am telling you what my beliefs, preferences and concerns are about my mental health problems and my care. I am giving you this information because I want my choices to be honored, and I want you to help me have as much control over my life as possible while I work on my recovery.

1. The following thoughts, feelings and wishes (including religious or philosophical beliefs, traditions, personal history, values, or other beliefs) are especially important for those involved in my care to know about me:

2. My mental health problems affect me in the following ways: (Describe the mental health problems that impair or disable you. You may include diagnosis.)

3. My capacity to make sound decisions about my care may be impaired when I have the following symptoms and behaviors:

4. The following things help me to relax and to feel better when I am having a difficult time:

- Participating in groups
- Having a particular person visit: _____
- Quiet time by myself (name)
- Talking to staff
- Talking to other patients
- Talking to a particular person: _____
- Listening to music (name)
- Exercise or taking a walk
- Calling my therapist
- Taking a bath or shower
- Taking a nap
- Other: Please list

5. The following things make it more difficult for me to calm down when I am upset or not doing well:

- Being made to disrobe/put on a gown
 - Being touched
 - Loud noises
 - Being isolated
 - People in uniform
 - Being put in seclusion
 - Having a particular person visit: _____
 - Being ignored or put off when I make a request for help (name)
 - Having other patients who I do not know try to talk to me
 - Not being allowed to smoke
 - Sharing a room
 - Having to participate in groups
 - Other: Please list
- _____
- _____
- _____
- _____

6. I have the following preference regarding gender of staff:

- women staff
- men staff
- no preference

B. MEDICATIONS

1. The following medications may **not** be given to me:

Medication	Reason it may not be given, including problems and risks:
a. _____	_____
b. _____	_____
c. _____	_____

If others, please attach additional sheet, and check this box.

2. The following medications **may be given** to me:

Medication	Dosage	When it may be given to me
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____

If others, please attach additional sheet, and check this box.

3. If a new medication is being proposed for me, my proxy/agent may act according to the following instructions to him/her:

- You shall not agree to the use of any new medication.
- You shall not agree to the use of a new neuroleptic medication.
- You may agree to a trial period of a new neuroleptic medication, but should stop if I get the following symptoms:

- You may agree to a trial period of a new anti-depressant or anti-anxiety medication, but should stop if I get the following symptoms:

- I will leave it up to your informed judgment on whether to try any new medications after you consult with my doctors about the possible risks and benefits.

C. ECT (ELECTRO-CONVULSIVE THERAPY) TREATMENT:

- I do not consent to the use of ECT.
- I consent to the use of ECT, with the following conditions or limits:

- I will leave it up to my proxy/agent to make this decision after consulting with my doctors about the possible risks and benefits of this procedure.

D. OTHER MENTAL HEALTH TREATMENT

1. My preferences about my need for crisis intervention and hospitalization: (Check those that apply.)

I would prefer that a crisis-stabilization alternative to inpatient hospitalization be tried first.

a. name of program _____ phone # _____

contact person _____ phone # _____

b. name of program _____ phone # _____

contact person _____ phone # _____

c. please find a program for me if none is listed.

If hospitalization is necessary, I would prefer to be hospitalized here:

a. name of hospital _____

b. name of hospital _____

I **do not** want to be hospitalized at the following hospitals:

a. name of hospital _____
reason _____

b. name of hospital _____
reason _____

2. My preferences about the doctors and nurses treating me:

My choice of treating doctors is:

a. name _____ phone # _____

b. name _____ phone # _____

I would like the treating doctor to consult with the following mental health professionals who help me in the community:

a. name _____ phone # _____

occupation _____

b. name _____ phone # _____

occupation _____

c. name _____ phone # _____

occupation _____

I **do not** want to be treated by the following doctors:

a. name _____

b. name _____

c. name _____

I **do not** want to be under the care of the following nurses or other health care practitioners:

a. name _____

b. name _____

c. name _____

3. My instructions about notification and visitors:

Notification of others. If I am hospitalized, I give permission for the following persons to be immediately notified, and to be given information about my condition and care:

a. name _____ phone #(h) _____

relationship _____ (w) _____

b. name _____ phone # (h) _____

relationship _____ (w) _____

Visits by the above persons are permitted, unless otherwise stated here:

I **do not** want the following people to visit me:

a. name _____ relationship _____

b. name _____ relationship _____

4. Other mental health instructions:

a. Emergency measures. If I am becoming dangerous to myself or another person, I prefer that you use the following interventions:

- Seclusion alone
- Restraint alone
- Both seclusion and restraint
- Oral medication
- Injection of medication
name: _____

b. I have a particular objection to some of the above interventions:

1. Intervention: _____
reason: _____

2. Intervention: _____
reason: _____

c. Exercise that is helpful:

d. Use of talk therapy. I can benefit by the following:

e. Other care or treatment that helps:

f. Other care or treatment that should **not** be part of my treatment:

II. APPOINTMENT OF A MENTAL HEALTH PROXY/AGENT (OPTIONAL BUT RECOMMENDED)

I appoint the following person(s) to act as my proxy/agent to make decisions about neuroleptics or ECT and my other mental health care needs. Decisions must be made according to my instructions and preferences. I know I can revoke this appointment or appoint a new proxy/agent at any time as long as I have the capacity to do so. This person(s) may be the same person(s) as my general health care agent(s), but does not have to be. These person(s) have consented to act as my mental health proxy/agent:

a. Designated proxy/agent:

name _____
relationship: _____
address: _____

telephone: (h) _____
(w) _____

b. Alternate proxy/agent:

name _____
relationship: _____
address: _____

telephone: (h) _____
(w) _____

III. INSTRUCTIONS ABOUT MY GENERAL HEALTH CARE

A. GENERAL INSTRUCTIONS AND PREFERENCES:

1. My spiritual, religious, or philosophical beliefs about my health care are:

2. My health care goals are:

3. My health problems, including other, non-mental health related diagnoses are:

4. Particular concerns about how my health might affect my family are:

5. (For women of child-bearing age) My preferences about how my care should be handled if I am pregnant are:

6. If I were completely dependent on others for my care and unable to speak for myself, I would want them to know these things:

7. This is how I feel about being admitted to a nursing home or other community residential facility:

8. These are my instructions about pain relief and other medications:

9. These are some other instructions about my general health care that you should follow if I am admitted to a hospital or other care facility:

10. **I have/have not** (circle one) completed a **Designated Standby Custodian** form to apply in the event I am hospitalized or otherwise am temporarily unable to provide care for my child/ren. That document is attached. (**Note: the designated standby custodian form must be renewed every year.**) I also have the following instructions about the care of my child/ren:

11. These are some instructions about my home, pets or other things that need to be done if I am admitted to a hospital or other care setting:

B. END-OF-LIFE INSTRUCTIONS AND PREFERENCES

1. End of life definition: Although I greatly value life, I also believe that at some point treatment other than comfort care (pain relief) should be stopped, and I should be allowed to die. For me, that point is the following:

When two (2) doctors have examined me and determined that: 1) I am in a terminal state, including a persistent vegetative state, and life support would only delay the moment of death; or 2) I have an irreversible condition, including a coma, from which there is no reasonable hope of recovery.

OR

My own decision about when I have reached that point, or other conditions under which I do not wish to be kept alive are:

2. Where I would like to die:

3. Other wishes about dying:

a. My wishes about burial/cremation:

b. My wishes about organ donation:

c. Other:

4. My wishes about specific end-of-life treatments:

a. Cardio-pulmonary resuscitation:

b. Being put on a respirator:

c. Dialysis (kidney machine)/major blood transfusions:

d. Artificial nutrition and hydration (“feeding tube”):

e. Other (including invasive tests, major surgery, chemotherapy etc.):

C. INSTRUCTIONS ABOUT PROVIDERS OF CARE AND TREATMENT

I would like to receive care for my physical health needs at the following hospital(s):

a. name: _____

b. name: _____

I would like to be under the care of the following doctor(s):

a. name: _____ phone # _____

b. name: _____ phone # _____

I **do not** want the following hospitals/doctors to care for me:

a. name: _____

b. name: _____

c. name: _____

I want these persons to be contacted if I am hospitalized and incapacitated, and to be given information

a. name _____ phone# (h) _____
relationship: _____ (w) _____

b. name _____ phone# (h) _____
relationship: _____ (w) _____

IV. APPOINTMENT OF PROXY/AGENT (OPTIONAL, BUT RECOMMENDED)

A. I hereby appoint my proxy/agent and grant him/her the following powers to make health care decisions for me in the event I lack the capacity to decide or speak for myself. I have discussed my health care directive with my proxy/agent(s) who has consented to act as my proxy/agent(s). I understand that I can appoint joint proxy/agent(s) or name an alternative agent. **I also understand that I may appoint the same person(s) as my proxy/agent(s) for my mental health care.**

Name _____
Relationship: _____
Address: _____
Phone: (h) _____
(w) _____

check one: joint agent alternate

Name _____
Relationship: _____
Address: _____
Phone: (h) _____
(w) _____

check one: joint agent alternate

If joint agents, can one of them act independently if necessary? yes no

B. POWERS OF MY PROXY/AGENT(S)

I authorize my proxy/agent(s) to do the following:

1. Make any health care decisions for me, including the power to give, refuse, or withdraw consent to my care, treatment or procedure, including stopping or starting care that might keep me alive. I have decided to limit this power as follows: (If no limits, check here.)

2. Choose my health care providers. I have decided to limit this power as follows: (If no limits, check here.)

3. Choose where I live and what care and services I receive. I have decided to limit this power as follows: (If no limits, check here.)

4. Review my medical records and release them to others. I have decided to limit this power as follows: (If no limits, check here.)

C. OPTIONAL POWERS

I authorize my proxy to do the following, which I understand are completely optional on my part:

- Decide where to donate my organs, according to my previous instructions.
- Decide what will happen to my body, according to my previous instructions.
- Make health care decisions, for me even though I still have the capacity to do so myself. I have decided to limit this Power as follows: (If no limits, check here.)

IV. AUTHORIZATION TO RELEASE INFORMATION

- A. I direct that my proxy/agent have the same right as I would to receive, review, and obtain copies of my medical records and to consent to disclosure of these records, with limitations as follows: (If none, check here.)

B. In the event that I am hospitalized and have not named a proxy/agent, I authorize the release of the following health, mental health and/or social service records to the hospital which I am in, with limitations as follows: (If none, check here.)

- a. _____
- b. _____
- c. _____
- d. _____

This also includes conversations between the hospital and the above providers, with limitations as follows: (If none, check here.)

C. If I am hospitalized, I request and authorize the hospital to notify the following persons, and to answer their questions about my care and treatment, with limitations as follows: (If none, check here.)

This authorization specifically includes re-release of all documents in my records obtained from any other sources, specifically including the re-release of any chemical dependency records which may be included, and is valid as long as this directive is in effect.

V. NOMINATION OF GUARDIAN OR CONSERVATOR (OPTIONAL)

My proxy/agent, (Name) _____ is/is not (circle one) nominated to be my guardian or conservator in the event a guardianship petition is filed. If my proxy or agent is not nominated, I nominate the following person:

Name _____
Address _____
Telephone(s) _____
Relationship (if any) _____

VI. GENERAL POWER OF ATTORNEY (optional)

I have/have not (circle one) completed a General Power of Attorney document to apply in the event I am hospitalized or otherwise mentally incapable to handle my financial affairs. That document is attached, or can be found in the following place:

VII. DISTRIBUTION OF DOCUMENT

I have given a copy of this directive to the following people.

This document, including all attached pages and the signature pages, consists of ____ pages. **Date and initial each page at the time you sign this document.**

VIII. SIGNING OF DOCUMENT

Sign and date here in the presence of two witnesses, neither of whom should be your proxy, agent or nominee for guardianship. You may sign in front of a notary only if you are filling out the Health Care Directive portion, but not the Mental Health portion.

I sign my name to this document on _____, _____. I am thinking clearly, I agree with everything written in this document and I have made these instructions willingly.

MY SIGNATURE
ADDRESS _____

PHONE _____
SOCIAL SECURITY # _____
(Optional, but helpful.)

WITNESSES:

I certify that I am at least eighteen (18) years of age and that in my presence on the date appearing above the principal signed or acknowledged the signing of this document. It is my belief that the principal fully understands the nature and significance of the declarations made herein. I am not named as proxy, agent or alternative in the document. If I am a mental health or other health care provider, or an employee of a health care provider providing direct care to the principal on or before the date appearing above, I have so noted below.

WITNESS SIGNATURE WITNESS SIGNATURE
Address _____ Address _____
Telephone _____ Telephone _____
Health Care Provider? Yes No Health Care Provider? Yes No

DATE

DATE

OR: NOTARIZATION, acceptable if only the health care portion but not the mental health portion is filled out:

STATE OF MINNESOTA
COUNTY OF _____

The foregoing document was signed or acknowledged before me this ____ day of _____, _____, by the principal therein. I am not the proxy, agent or alternative in the foregoing document.

Notary Public

**Designated Standby Custodian
(Minnesota Statutes Chapter 257B)**

A. I, _____, appoint _____,
(Please print name and relationship to children) (Please print name of Designated Parent)

(address and telephone number)

as the standby custodian for: _____
(Child/ren's names, **please print**)

to take effect upon the occurrence of the following triggering event(s): _____

If I have indicated more than one triggering event, it is my intent that the triggering event which occurs first shall take precedence. If I have indicated "my death" as the triggering event, it is my intent that the person named in the designation to be standby custodian for my child(ren) in the event of my death shall be appointed as guardian of my child(ren) under Minnesota Statutes, section 525.551, upon my death.

B. _____ is the other parent. His/her address and
(Name of Other Parent)
telephone number are: _____.

Here is additional information about the other parent. (Check all that apply):

_____ The other parent died on _____.
(date of death)

_____ The other parent's parental rights were terminated on _____.
(date of termination)

_____ The other parent's whereabouts are unknown. (I understand that all living parents whose rights have not been terminated must be given notice of this designation pursuant to the Minnesota Rules of Civil Procedure or a petition to approve this designation may not be granted by the court.)

_____ The other parent is unwilling and unable to make and carry out day-to-day child-care decisions concerning the child(ren).

_____ The other parent consents to this designation and has signed this form below.

C. By this designation I am granting _____
(Name of Standby Custodian)
the authority to act for 60 days following the occurrence of the triggering event as a co-custodian with me, or in the event of my death, as custodian of my child(ren).

_____ **Alternate:** (Optional) I hereby nominate _____,
(Name of Alternate Standby Custodian)

(Address and Telephone Number of Alternate Standby Custodian)
as the alternate standby custodian to assume the duties of the standby custodian named above if the standby custodian is unable or unwilling to act as a standby custodian.

It is my intention to retain full parental rights to the extent consistent with my condition and to retain the authority to revoke the appointment of a standby custodian if I so choose.

D. This designation is made after careful reflection, while I am of sound mind.

(Date)

(Designator's Signature)

(Witness' Signature)

(Witnesses' Signature)

(Number and Street)

Number and Street)

(City, State, and Zip Code)

(City, State, and Zip Code)

IF APPLICABLE: I, _____,
(Name of Other Parent)
hereby consent to this designation.

(Date)

(Signature of Other Parent)

(Address of Other Parent)

I, _____ hereby accept my nomination as standby
(Name of Standby Custodian)
custodian of _____
(Child(ren)'s Name(s))

I understand that my rights and responsibilities toward the child(ren) named above will become effective upon the occurrence of the above-stated triggering event or events. I further understand that in order to continue caring for the child(ren), I must file a petition with the court within 60 days of the occurrence of the triggering event.

(Date)

(Signature of Standby Custodian)

Minnesota Disability Law Center Advance Psychiatric Directive Satisfaction Survey

Instructions: The following questions are designed to help the Minnesota Disability Law Center gauge the effectiveness of the advance directive materials we give out to consumers and service professionals. We appreciate any and all feedback as it will allow us to adapt our information and materials to fit the needs of our audience. You will remain anonymous. Thank you!!!

1) The information provided about advance directives was useful to me.

Strongly agree__

Agree__

Disagree__

Strongly disagree__

Do not know/not an issue__

2) The information was presented in a clear and concise manner.

Strongly agree__

Agree__

Disagree__

Strongly disagree__

Do not know/not an issue__

3) What sections of this information did you feel were the most helpful? Why?

4) What parts, if any, do you feel need to be changed? Why?

5) After reading the materials did you actually complete an advance directive?

Yes__ No__

Are you planning to sometime in the future?

Yes__ No__

6) Would you attend a training session on advance directives if one were offered in your area?

Yes__ No__

Minnesota Disability Law Center
Advance Psychiatric Directive Training Session Satisfaction Survey

Instructions: The following questions are designed to help the Minnesota Disability Law Center gauge the effectiveness of the advance directive materials we give to consumers and service professionals and the training sessions we conduct on this topic. We appreciate any and all feedback as it will help us to adapt our information and materials to fit the needs of our audience. Use the back if you need more room to write. You will remain anonymous. Thank you!!!

1) The presenter/trainer appeared knowledgeable about the materials and did their best to answer questions.

- Strongly agree__
- Agree__
- Disagree__
- Strongly disagree__
- Do not know/not an issue__

2) The information was presented in a clear and concise manner.

- Strongly agree__
- Agree__
- Disagree__
- Strongly disagree__
- Do not know/not an issue__

3) Are there terms or topics we discussed that you feel need greater clarity?

4) What parts of the advance directive are most relevant/important to you or your organization?

5) Did you gain any information overall that was particularly valuable to you/your organization?

6) What could we do to improve the materials or the training you received?

7) I feel more confident in my ability to create an advance directive because of this training.

- Strongly agree__
- Agree__
- Disagree__
- Strongly disagree__
- Do not know/not an issue__

8) I have completed an advance directive during this session or will be doing so afterward

- Yes__
- No__
- Not Sure__