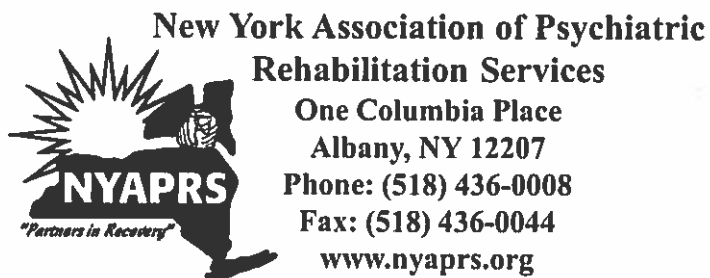


# PLANNING FOR YOUR MENTAL AND PHYSICAL HEALTH CARE AND TREATMENT

THE ADVANCE DIRECTIVE PROVIDER TRAINING PROJECT



This Document was created by The Resource Center, Albany, NY.

## GENERAL QUESTIONS ABOUT ADVANCE DIRECTIVES

An Advance Directive is a type of written or verbal instruction about health care to be followed if a person becomes unable to make decisions regarding his or her medical treatment. Because you prepare an Advance Directive when you are competent, it will be followed during periods of time when you lack capacity to make medical treatment decisions. There are several different types of Advance Directives, including a *health care proxy*, a *living will*, and a *do not resuscitate (DNR) order*. Each one of these is described in this pamphlet.

### **Why should I create an Advance Directive?**

Sometimes, because of illness or injury, people are not able to decide about treatment for themselves. You may want to plan in advance and create an Advance Directive to appoint a health care agent and/or make your wishes and instructions known regarding your mental and physical health care, so that these wishes may be followed if you become unable to decide for yourself for a short or long term period. If you don't plan ahead, family members or other people close to you may not be allowed to make decisions for you or follow your wishes, and/or no one will know what treatment choices you may have preferred.

### **How do I create an Advance Directive?**

You can use the form and directions in this pamphlet or have an attorney create an alternative form for you. The New York State Department of Health can provide you with forms and information regarding Advance Directives as well.

### **Can anyone refuse to provide me with mental or physical health treatment because I have created an Advance Directive?**

*No.* It is against the law for treatment providers to discriminate against someone because he or she has an Advance Directive.

### **On what basis will a physician determine that I am incapable of making mental and physical health care decisions?**

Your capacity to consent to mental and physical health care is determined by your ability to understand the nature and consequences of health care decisions, including the benefits, risks, and alternatives to proposed treatment, and then to make an informed choice.

### **Can I make decisions in advance using an Advance Directive about whether or not I want involuntary psychiatric hospitalization?**

*No.* New York State Mental Hygiene Law Article 9 governs the admission of patients to a hospital for involuntary psychiatric care. You therefore cannot make decisions regarding whether or not to undergo involuntary psychiatric hospitalization in an Advance Directive.

### **If I object to any mental health treatment when my Advance Directive is in effect, will my objection be honored?**

Your present objection to treatment will override the instructions contained in your Advance Directive and/or the decisions made by your health care agent. You will have the same rights regarding your present objection to treatment that you would have had if you made no Advance Directive.

**If I wish to use the attached form as my Advance Directive, must I complete the entire form?**

If you choose to use the attached form, you should make sure that your name is stated at the beginning of each form and that the section regarding signatures and witnesses is completed as necessary. However, you can choose whichever other sections within the form regarding your treatment decisions that you wish to complete. *It is your choice whether to fill out this form and what provisions to include in it.*

**May anyone help me to fill out the Advance Directive form in this pamphlet?**

You may ask anyone you wish to help you fill out the Advance Directive form. You may want to discuss its provisions with your mental or physical health care treatment providers. A mental health peer advocate who has been trained to assist in preparing Advance Directives may also be helpful. However, you must make the final decisions and sign the Advance Directive. You cannot be forced to fill out an Advance Directive by anyone, including a family member or treatment provider.

**To whom should I give copies of my Advance Directive?**

You should give copies of your Advance Directive to your health care agent and alternate agent (if you have appointed them), to the treatment providers and health care professionals who routinely provide care to you, and to your family or friends. You may also want to give a copy to the hospital where you are likely to be treated if the need arises, and to keep a copy with your important papers.

**HEALTH CARE PROXIES**

**What is a Health Care Proxy?**

A New York Law called the Health Care Proxy Law allows you to appoint someone you trust and who knows you well, such as a family member or close friend, who will agree to act in your best interests regarding your health care if you lose the ability to make decisions about treatment for yourself. The document in which you appoint this person as your health care agent is called a Health Care Proxy.

**What is the purpose of a Health Care Proxy?**

The Health Care Proxy Law gives you the power to ensure that health care professionals know your wishes regarding medical treatment. Your health care agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors, and other health care providers must follow your agent's decisions as if they were your own.

**If I appoint a health care agent, how much authority does he or she have to make treatment decisions on my behalf?**

You can give your agent as little or as much authority as you want. You can allow your agent to decide about all health care or only certain treatments. For example, you may appoint a health care agent to make decisions only about your mental health care. However, you may not appoint more than one health care agent to act at a given time (e.g., you cannot appoint one for physical health care decisions and one for mental health care decisions).

If your health care agent is not aware of your wishes about artificial nutrition and hydration (nourishment and water provided by feeding tubes), he or she will not be able to make decisions about these measures.

You may also give your agent instructions that he or she has to follow. Your agent must follow your verbal and written instructions, as well as your moral and religious beliefs. You may include a living will and/or a statement of your preferences and desires regarding medical treatment with your health care proxy, which can

provide a useful resource for your health care agent. If your agent does not know your wishes and beliefs, your agent is legally required to act in your best interests.

### **How does appointing a health care agent empower me?**

Appointing an agent lets you control your medical treatment by:

- allowing your agent to stop treatment when he or she decides that is what you would want or what is best for you under the circumstances; and
- choosing one person to decide about treatment because you think that person would make the best decisions or because you want to avoid conflict or confusion about who should decide.

### **What are the advantages of creating a Health Care Proxy?**

The purpose of the Health Care Proxy law is to give a person of your choice the authority to speak for you when you are incapacitated to ensure that decisions regarding your medical treatment are made in accordance with your wishes, including your religious and moral beliefs if known to your agent, or, if your agent does not know your views, in accordance with your best interests. Therefore, a major advantage in appointing a health care agent through a Health Care Proxy is that you do not have to know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made. The Health Care Proxy is just as useful for decisions to receive treatment as it is for decisions to stop treatment.

### **What are the disadvantages of creating a Health Care Proxy?**

It is very important that the person you choose to be your health care agent be an adult that you trust to protect your wishes and interests. If there is no such adult in your life, you may wish to consider a Living Will to provide guidance about your attitudes and preferences regarding your medical care.

### **Who should I choose to be my health care agent?**

The health care agent must be an adult 18 years of age or older. It is not necessary that he or she reside in New York State. You should choose a person you trust to protect your wishes and interests.

An operator, administrator or employee of a general hospital, nursing home, mental hygiene facility, or hospice cannot serve as an agent for you if you are a patient at the facility, unless you are related to the person you wish to appoint, or you created the Health Care Proxy before being admitted to, or applying for admission to, the facility.

You can appoint your physician as your agent, but the physician will not be able to serve both as your agent and your attending physician after his or her decision-making authority as your agent begins. Furthermore, if you appoint a physician as your agent, that physician cannot determine your capacity to make health care decisions.

### **How can I appoint a health care agent?**

All competent adults can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer, just two adult witnesses.

You can use the form in this pamphlet, but you don't have to.

### **When would my health care agent begin to make treatment decisions for me?**

Your health care agent would begin to make treatment decisions after doctors decide that you are not able to make health care decisions. If you regain capacity to make health care decisions, the health care agent's

decisionmaking authority ends. *As long as you are able to make treatment decisions for yourself, you will have the right to do so.*

### **Will my agent's decisions be honored?**

All hospitals, doctors, and other health care facilities are legally required to honor the decisions by your agent, unless they obtain a court order overriding the decision.

### **What if my health care agent is not available when decisions must be made?**

You can appoint an alternate agent to decide for you if your health care agent is not available or able to act when decisions must be made. Otherwise, health care providers will make treatment decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

### **What are the requirements for signing and witnessing a Health Care Proxy?**

You must sign and date a Health Care Proxy in order for it to be enforceable. You must include the name of your agent and state that you intend the agent to make health care decisions for you.

You must sign the Health Care Proxy in the presence of two witnesses who are 18 years of age or older. Neither witness can also be the person who you are appointing as your health care agent. The witnesses must also sign the document and state their belief that you are personally known to them, you appear to be of sound mind, and you are acting of your own free will. If you create your Health Care Proxy while you are a resident in a facility operated or licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities, one of those witnesses **cannot** be affiliated with that facility. And, if the facility in which you reside is a hospital, at least one of those witnesses must be a "qualified" psychiatrist (i.e., he or she is board eligible or board certified).

### **What if I change my mind?**

You should review your Health Care Proxy periodically to ensure that the document you signed still represents your current wishes. It is easy to cancel the proxy, to change the person you have chosen as your health care agent, or to change any treatment instructions you have written on your Health Care Proxy form. All you need to do is fill out a new form, or simply state that the Health Care Proxy is revoked.

You should notify your agent, your attorney, your physician or any other health care provider, your family and friends, and anyone who has a copy, verbally and in writing, of your change or revocation.

### **How long is a Health Care Proxy valid?**

The Health Care Proxy will be valid unless and until you cancel it. In addition, you can require that the Health Care Proxy expire on a specified date or if certain events occur. If you choose your spouse as your health care agent and you get divorced or legally separated, the appointment is automatically canceled.

## **LIVING WILLS**

### **What is a Living Will?**

A Living Will is a written document in which you, as an adult who is now competent, can express your wishes regarding your future health care in the event that you are unable to make health care decisions. You can also include a statement of your preferences and desires regarding medical treatment with your Living Will, which can provide a useful resource for your treatment providers.

### **Is a Living Will valid in New York State?**

Unlike the Health Care Proxy, there is no specific law in New York that establishes Living Wills. However, the courts in New York have honored Living Wills that have established a person's wishes by "clear and convincing proof." That is, it must be shown that the person who has become incapable had previously given clear and specific instructions regarding a certain type of medical care or procedure.

### **What is the difference between a Living Will and a Health Care Proxy?**

A Living Will is a document in which you can give specific instructions about your health care treatment, as well as express your attitudes and wishes about your health care.

A Health Care Proxy is different because it allows you to choose someone you trust to make treatment decisions on your behalf in case you lose your decision-making capacity. With a Health Care Proxy, you don't need to know in advance what will happen to you or what your medical needs might be in the future.

### **How does creating a Living Will empower me?**

A Living Will serves to make your wishes and instructions known regarding your mental and physical health care, if you become incapable of making treatment decisions. Treatment providers should follow your specific instructions. The instructions you write in this document would be evidence of your expressed wishes in the event that your wishes are challenged in court.

### **What are the advantages of a Living Will?**

If you have no one you can appoint to be your health care agent, or you do not wish to appoint one, yet you still want to make your wishes about your health care preferences known, a Living Will is a legally valid way of recording these instructions. This information will provide evidence of your wishes should you become incapable of making treatment decisions.

### **What are the disadvantages of a Living Will?**

General instructions about refusing treatment, even if written down, may not be effective if they do not meet the "clear and convincing proof" test. Further, expressions of intent regarding unforeseen circumstances or new developments in technology cannot be reflected in a Living Will unless it is routinely updated.

### **Can I create both a Health Care Proxy and a Living Will?**

Yes. If you complete a Health Care Proxy form, but also have a Living Will, the Living Will provides instructions for your health care agent, and will guide his or her decisions. Copies of your Living Will should be given to your health care agent. You will want to have your health care agent share the views expressed in the Living Will with your health care providers to make sure your wishes are understood. With both documents, if you include a statement of your preferences regarding your medical treatment, it will provide additional useful guidance.

### **What are the requirements for signing and witnessing a Living Will?**

Because there is not a specific law that governs Living Wills, there are no exact requirements with regard to signatures and witnesses. However, it is recommended that you follow the requirements for signing and witnessing a Health Care Proxy when executing a Living Will.

### **What if I change my mind?**

You should review your Living Will from time to time to ensure that the document you signed still represents your current wishes. You can change or revoke your Living Will by making a new one, destroying it, or

simply stating that it is revoked. You should be sure to tell your treatment providers and your family and/or friends that you have revoked your Living Will.

### **How long is a Living Will valid?**

The Living Will should be valid unless and until you revoke it.

## **DO NOT RESUSCITATE (DNR) ORDERS**

### **What is a DoNot-Resuscitate (DNR) Order?**

Cardiopulmonary resuscitation (CPR) refers to the medical procedures used to restart a person's heart and breathing when the person suffers heart failure. CPR may involve simple efforts such as mouth-to-mouth resuscitation and external chest compression. Advanced CPR may involve electric shock, insertion of a tube to open the patient's airway, injection of medication into the heart and, in extreme cases, open chest heart massage.

*A do not resuscitate (DNR) order tells medical professionals not to perform CPR.* This means that doctors, nurses, and emergency medical personnel will not attempt emergency CPR if the patient's breathing or heartbeat stops. A DNR order is only a decision about CPR and does not relate to any other treatment.

### **Can I request a DNR Order?**

Yes. All adult patients can request a DNR order.

If you have not requested a DNR order and have not appointed a health care agent to decide for you, a family member or close friend can consent to a DNR order when you are terminally ill, permanently unconscious, CPR will not work (would be medically futile) or CPR would impose an extraordinary burden on you given your medical condition and the expected outcome of CPR. Anyone deciding for you must base the decision on your wishes, including your religious and moral beliefs, or if your wishes are not known, on your best interests.

### **How can I make my wishes about DNR known?**

During hospitalization, an adult patient may consent to a DNR order verbally or in writing, if two adult witnesses are present. When consent is given verbally, one of the witnesses must be a physician affiliated with the hospital. Prior to hospitalization, consent must be in writing in the presence of two adult witnesses. In addition, the Health Care Proxy law allows you to appoint someone you trust to make decisions about CPR and other treatments if you become unable to decide for yourself.

### **What if I lose the ability to make decisions about CPR and do not have anyone who can decide for me?**

A DNR order can be written if two doctors decide that CPR would not work or if a court approves of the DNR order. It would be best if you discussed your wishes about CPR with your doctor in advance.

### **What if I change my mind?**

You or anyone who consents to a DNR order for you can revoke consent for the order by telling your doctor, nurses, or others of the decision.

**NOTE: THESE DIRECTIONS AND FORMS ARE NOT INTENDED TO CONSTITUTE LEGAL ADVICE. YOU MAY WISH TO CONSULT WITH YOUR OWN ATTORNEY FOR ADVICE SPECIFIC TO YOUR SITUATION.**

# ADVANCE DIRECTIVE FOR MENTAL & PHYSICAL HEALTH CARE

I, \_\_\_\_\_, hereby make known my desire that, should I lose the capacity to make health care decisions, the following are my instructions regarding consent to or refusal of medical treatment, and if I choose, the designation of my health care agent. I intend that all completed sections of this advance directive be followed.

## PART I. HEALTH CARE PROXY

A. **APPOINTMENT OF A HEALTH CARE AGENT:** I hereby appoint the following individual as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This health care proxy shall take effect when and if I become unable to make my own health care decisions.

\_\_\_\_\_  
(Agent's Name)

\_\_\_\_\_  
(Agent's Home Address)

\_\_\_\_\_  
(Agent's Telephone Number)

B. **AUTHORITY OF HEALTH CARE AGENT:** My health care agent may make decisions regarding\* (choose ONE):

- all mental and physical health care
- mental health care ONLY
- physical health care ONLY
- the following health care decisions ONLY \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*\*Note: While you may limit your health care agent's decision-making authority, you cannot appoint more than one health care agent at a time. For example, you cannot appoint one health care agent to make only physical health care decisions and another one to make only mental health care decisions.*

C. **ALTERNATE HEALTH CARE AGENT (optional):** If the person appointed above is unable or unwilling to serve as my health care agent, I hereby appoint the following individual to act as my alternate health care agent.

\_\_\_\_\_  
(Agent's Name)

\_\_\_\_\_  
(Agent's Home Address)

\_\_\_\_\_  
(Agent's Telephone Number)



**D. DURATION OF PROXY:** Unless I revoke it, this health care proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specify date or conditions, if desired):

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**PART II. STATEMENT OF DESIRES AND INSTRUCTIONS REGARDING MENTAL AND PHYSICAL HEALTH CARE AND TREATMENT**

I direct my agent to make health care decisions in accordance with my wishes and limitations as stated in this Advance Directive, or as he or she otherwise knows. If I have not appointed a health care agent, I wish my health care providers to act in accordance with my instructions as stated below.

*[Note: Unless your agent knows your wishes about artificial nutrition and hydration (tube feeding), your agent will not be allowed to make decisions about artificial nutrition and hydration.]*

**A. SPECIAL INSTRUCTIONS REGARDING MY MENTAL HEALTH CARE AND TREATMENT**

**1. Medications for Psychiatric Treatment:** If it is determined that I am not legally capable of consenting to or refusing medications relating to my mental health treatment, my wishes are as follows:

- (a) I prefer to be given the following medications  
MedicationName:

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- (b) I prefer not to be given the following medications, for the following reasons:

Medication: \_\_\_\_\_

Reason: \_\_\_\_\_

Medication: \_\_\_\_\_

Reason: \_\_\_\_\_

Medication: \_\_\_\_\_

Reason: \_\_\_\_\_

**2. Treatment Facilities:** If my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care the following are my instructions.

(a) I would prefer to receive this care at the following hospitals or programs/facilities, if possible:

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(b) I prefer not to receive this care at the following hospitals or programs/facilities, if possible, for the reasons I have listed:

Facility: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility: \_\_\_\_\_

Reason: \_\_\_\_\_

(c) My choice of treating physician, if possible, is:

\_\_\_\_\_ Phone # \_\_\_\_\_

*OR*

\_\_\_\_\_ Phone # \_\_\_\_\_

*OR*

\_\_\_\_\_ Phone # \_\_\_\_\_

(d) I do not wish to be treated by the following physicians, if possible, for the reasons stated:

Dr.'s Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Dr.'s Name: \_\_\_\_\_

Reason: \_\_\_\_\_

**3. Additional Instructions Regarding My Mental Health Care:** (e.g., individual psychotherapy, group therapy, electroconvulsive therapy, self-help services, research):

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**B. SPECIAL INSTRUCTIONS REGARDING MY PHYSICAL HEALTH CARE AND TREATMENT**

1. These wishes should be followed if: *(choose one of the following)*

I am terminally ill, in a coma or unconscious, or in an irreversible condition from which there is no reasonable hope of recovery, **OR**

the following medical conditions exist:

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2. Medical treatment about which you may wish to give your agent or health care providers special instructions include the following treatments. Write instructions for each treatment you choose on the lines provided.

Artificial respiration: \_\_\_\_\_

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Artificial nutrition and hydration: \_\_\_\_\_

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Cardiopulmonary resuscitation: \_\_\_\_\_

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Antibiotics: \_\_\_\_\_

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Dialysis: \_\_\_\_\_

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Transplantation: \_\_\_\_\_

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Blood transfusions or blood products: \_\_\_\_\_

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Invasive diagnostic tests: \_\_\_\_\_

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Other physical health treatments or medications: \_\_\_\_\_

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**Additional instructions regarding physical health care and treatment:**

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### PART III. IMPORTANT INFORMATION IF I AM HOSPITALIZED

*(You may choose to complete this section to provide additional guidance to your health care agent and/or providers.)*

I wish to provide the following information regarding my current mental health care and treatment and to state my preferences regarding mental health care and treatment, in the event I am hospitalized. I strongly hope that my stated preferences will be honored to assist me in having more control over my life and to aid in my recovery.

**A. MY PHYSICIAN AND/OR PSYCHIATRIST'S NAME AND ADDRESS:**

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**B. MY OUTPATIENT MENTAL HEALTH CARE PROVIDER(S):**

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**C. APPROACHES THAT HELP ME WHEN I'M HAVING A HARD TIME:**

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

- |  |   |
|--|---|
| <input type="checkbox"/> Voluntary time out in my room   | <input type="checkbox"/> Listening to music       |
| <input type="checkbox"/> Voluntary timeout in quiet room | <input type="checkbox"/> Reading                  |
| <input type="checkbox"/> Sitting by staff                | <input type="checkbox"/> Watching TV              |
| <input type="checkbox"/> Talking with a peer             | <input type="checkbox"/> Pacing the halls         |
| <input type="checkbox"/> Having my hand held             | <input type="checkbox"/> Calling a friend         |
| <input type="checkbox"/> Going for a walk                | <input type="checkbox"/> Calling my therapist     |
| <input type="checkbox"/> Punching a pillow               | <input type="checkbox"/> Pounding some clay       |
| <input type="checkbox"/> Writing in a journal            | <input type="checkbox"/> Deep breathing exercises |
| <input type="checkbox"/> Lying down                      | <input type="checkbox"/> Taking a shower          |
| <input type="checkbox"/> Talking with staff              | <input type="checkbox"/> Exercising               |

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**D. ACTIONS THAT ARE NOT HELPFUL:**

In the past, I have found that the following actions make me feel worse. I prefer that staff not do the following:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**E. PREFERENCES REGARDING PHYSICAL CONTACT BY STAFF:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**F. HOSPITAL AND COMMUNITY TREATMENT PROGRAMS:** (outpatient clinics, community based residential facilities, community support programs, self-help programs, etc.)

Upon my discharge, if possible, I would like to receive treatment from the following hospitals and community treatment programs:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Upon my discharge, if possible, I do not want to receive treatment from the following hospitals or community treatment programs for the reasons listed:

Provider: \_\_\_\_\_

Reason: \_\_\_\_\_

Provider: \_\_\_\_\_

Reason: \_\_\_\_\_

Provider: \_\_\_\_\_

Reason: \_\_\_\_\_

**G. ADDITIONAL PREFERENCES REGARDING MY MENTAL HEALTH CARE AND TREATMENT:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## PART IV. SIGNATURE AND STATEMENT OF WITNESSES

A. Your Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

B. Statement by Witnesses (must be age 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

Witness 2: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

NOTE: If you are a resident at an OMH or OMRDD operated or licensed facility, special witnessing requirements apply. See instructions or ask staff to assist you.

Directions: Print this card, furnish your information, then cut around the black line and fold at the dotted line. This card should be carried in your wallet.

**Advance Directives Alert Card**  
The person carrying this card

\_\_\_\_\_

has a Mental and Physical Advance Directive  
on file. Please see the reverse side before  
providing any treatment.

\_\_\_\_\_ Phone #

\_\_\_\_\_ My Health Care Agent is:

\_\_\_\_\_ I have an Advance Directive on file at: