Handbook for

Substitute Decision-Makers

Prepared by:

The Office of the Attorney General
With funds provided by the
Office of the Ombudsman for
Mental Health and Mental Retardation
State of Minnesota

Created September 1999
Updated by the Office of the Ombudsman for Mental Health and Mental Retardation January 2002

TABLE OF CONTENTS

APPENDICES

HANDBOOK FOR SUBSTITUTE DECISION-MAKERS

INTRODUCTION

This Handbook will help you do your work as a substitute decision-maker (abbreviated as "SDM") for a civilly committed person whose doctor has recommended treatment with antipsychotic (neuroleptic) medication and who is not refusing the medication. The first section of the Handbook will discuss some of the concepts that underlie substitute decision-making. The second section will give some practical suggestions on how to carry out your responsibilities. The final section will answer questions that are frequently asked by and about SDMs.

In addition, appendices are included that include the text of the section of the Minnesota Commitment and Treatment Act, Minnesota Statutes section 253B.092, that governs substitute decision-makers, a list of neuroleptic or antipsychotic medications currently being used, and other useful forms.

I. CONCEPTS.

Here is a brief explanation of the most important concepts that you need to understand to do your work.

A. What Is Informed Consent?

Informed consent means consent given by a person to a doctor (or other health care provider) to administer some kind of medical treatment. The consent is "informed" if it is voluntary and given after the person has been informed of the nature of his or her condition, how the treatment is supposed to help, and the risks that may accompany the treatment. As a general rule, a doctor may not treat a patient without that patient's informed consent for the treatment.

B. What Is Neuroleptic Medication?

Neuroleptic medication, also known as "antipsychotic" medication, is a form of medication that is widely accepted as the treatment of choice for persons with a variety of psychiatric disorders, particularly psychosis. A list of currently used medications is included as Appendix 2. These medications help restore a chemical balance in the brain and help persons reduce psychotic thinking, distorted perceptions, emotional disturbance, and pathological behaviors. Some neuroleptics, particularly older ones, carry with them a broad range of possible side effects varying from annoying to disabling to, in rare cases, fatal. An affidavit used by physicians giving a more detailed explanation of neuroleptics is attached as Appendix 3.

Primarily because of the potential for serious side-effects, Minnesota courts have decided that neuroleptic medications are legally more "intrusive" than other forms of mental health treatment. The law therefore requires special procedures before neuroleptic medication can be administered to civilly committed patients. The SDM procedure is one of them.

C. What Is Civil Commitment?

Civil commitment is a legal process for compelling a person with mental illness to go to a hospital or other treatment setting for the purpose of receiving treatment. In order to commit a

person, a petitioner (usually the county) must prove to a judge that the proposed patient has a mental illness (as defined by statute), that the person poses a risk of harm to self or others, and that nothing short of civil commitment will be sufficient to protect the patient or the public.

In most instances, civil commitment is for a specific period of time, usually six months or a year. (For persons committed as mentally ill and dangerous to the public (MI&D), there is no time limit on the commitment.) Remember that persons may be committed to community-based, non-residential programs and need not be in a traditional "hospital" to be considered civilly committed. For purposes of substitute decision-making, a person should be considered "committed" if he or she is on a hold order (a temporary order permitting the person to be confined pending a hearing in the commitment petition), subject to early intervention under Minnesota Statutes §§ 253B.064-.066, or committed for treatment under Minnesota Statutes § 253B.09.

D. What Are Capacity And Incapacity?

By definition, mental illness affects the way a person thinks or perceives reality; this fact often makes the concept of informed consent problematic for persons with mental illness. When a person has a serious mental illness, his or her ability to give or refuse informed consent may be severely impaired or nonexistent because the illness (1) interferes with the person's ability to comprehend factual information about the illness or the treatment; (2) makes it difficult or impossible for the person to weigh the benefits and risks of treatment; (3) causes the person to make decisions based on delusions rather than reality; or (4) makes it difficult or impossible for the person to communicate a decision.

A person whose illness is so severe that he or she is unable to make an informed decision is called "incapacitated" (or, sometimes, "incompetent") to make that decision. In such circumstances, in order to treat a person with mental illness, someone else must be asked to give or withhold informed consent on the incapacitated person's behalf.

However; the law says that a person is *presumed* to have capacity *unless* there is evidence of incapacity even if the person is so ill that he or she must be committed. For purposes of consent for neuroleptic medication, capacity is determined by applying the following factors:

> (1) whether the person demonstrates an awareness of the nature of the person's situation, including the reasons for hospitalization, and the possible consequences of refusing treatment with neuroleptic medications;
>
> (2) whether the person demonstrates an understanding of treatment with neuroleptic medications and the risks, benefits, and alternatives; and
>
> (3) whether the person communicates verbally or nonverbally a clear choice regarding treatment with neuroleptic medications that is a reasoned one not based on delusion, even though it may not be in the person's best interests.
>
> Disagreement with the physician's recommendation is not evidence of an unreasonable decision.

Minn. Stat. § 253B.092, subd. 5 (b) (1998). Note that all three of the criteria must be present for the person to have capacity.

In order for an SDM to be appointed by a court, the person asking for an appointment must declare that the patient lacks capacity, using the above criteria.

E. When Is A Person Refusing Medication?

An SDM may give consent to treatment only if the patient is not refusing medication. What constitutes a "refusal" is not clearly spelled out in statute, but the Minnesota Department of Human Services uses the following definition:

> A patient's verbal or nonverbal behavior demonstrating a clear rejection of the neuroleptic medication. Occasionally declining medication is not to be considered a refusal unless the patient declines so often or in such a way that effective treatment is not possible.

This definition recognizes that patients may equivocate about accepting treatment. Such equivocation is not considered refusal unless it makes effective treatment impossible. For example, a patient who won't take the medication at night but will take it in the morning is not "refusing" and can still be treated with the SDM's consent (as long as the treatment team agrees that the person can be effectively treated in this way).

Similarly, the definition focuses on the patient's *behavior.* A patient who is offered medication and says "I don't want it" but takes it anyway is not refusing; a patient who says "OK, I'll take the medication" but cheeks it and spits it out later, and does it so often that the treatment is not effective, is refusing.

F. What Should I Consider In Making The Decision?

The law requires the SDM to first try to decide what the patient would want done if the patient were able to make a reasoned decision. If you can't find out what the person would want to have done, or if there is evidence both ways, you should determine whether a reasonable person in similar circumstances would agree to take the medication or not. Here is the text of the statute:

> If the person clearly stated what the person would choose to do in this situation when the person had the capacity to make a reasoned decision, the person's wishes must be followed. Evidence of the person's wishes may include written instruments, including a durable power of attorney for health care under [Minnesota Statutes] chapter 145C or a declaration under [Minnesota Statutes] section 25313.03, subdivision 6d.
>
> If evidence of the person's wishes regarding the administration of neuroleptic medications is conflicting or lacking, the decision must be based on what a reasonable person would do, taking into consideration:
>
> (1) the person's family, community, moral, religious, and social values;
>
> (2) the medical risks, benefits, and alternatives to the proposed treatment;

(3) past efficacy and any extenuating circumstances of past use of neuroleptic medications; and

(4) any other relevant factors.

Minn. Stat. § 253B.092, subd. 7(c).

G. What Are Advance Directives?

An advance directive is a legal document that sets forth in advance the person's wishes and preferences with regard to health care treatment if the person becomes incapacitated and unable to make decisions for him- or herself. A durable power of attorney for health care or an advance mental health declaration, mentioned in the statute above, are examples of advance directives.

For example, a person who knows that neuroleptic medication has helped in the past may, during a time he or she is well, write in a durable power of attorney for health care, "If I should become psychotic, I want to be treated with neuroleptic medication." This statement, if made when the patient had capacity, is strong evidence of what the person would want done and you must follow it.

An advance directive may also name another person as a proxy or health care agent who can make decisions if the person becomes incapacitated. If you find an advance directive naming someone else as a proxy, you should check with the court to see why this person wasn't named SDM.

II. SUBSTITUTE DECISION-MAKING: STEP-BY-STEP.

A. Introduction.

Your job as an SDM is to decide whether to consent to treatment with neuroleptics on behalf of a person who is (1) civilly committed; (2) incapacitated; and (3) is not refusing medication. This section outlines the steps you should follow in carrying out that responsibility. This is just a guide. You should feel free to modify it as necessary. Just remember that you have been asked to make an important decision regarding the life and health of another person, and you will want to be as conscientious as you can in making that decision.

Essentially, here are the steps you should follow:

- Verify your appointment as SDM
- Gather information from the treatment facility and the patient
- Make a decision whether or not to consent
- Report your decision to the court.

1. Confirm your appointment as an SDM.

You should be sure that you have been properly appointed as SDM for a committed person. Generally, you should receive a written court order appointing you. You should be sure that the order sufficiently identifies the patient on whose behalf you will be working and that you are the person who has been appointed. A copy of the order should have been provided by the court to

the patient, the patient's attorney, the county attorney, the treatment program, and the county mental health agency providing services to the patient.

How appointed. How you got to be appointed depends on how your county does things. The law says that "An[y] individual or a community or institutional multidisciplinary panel designated by the local mental health authority" may be appointed as an SDM. *See* Minn. Stat. § 253B.092, subd. 6(a). Each county mental health agency is thus free to design its own system for identifying, recruiting, and training SDMs. They may choose to appoint mental health professionals (nurses, social workers, psychologists), or community volunteers, friends of the patient, or members of patient's families.

Guardians and conservators. The law also provides that, if the patient has a guardian or conservator already appointed to make medical decisions for the person, that person should receive a preference in being appointed. Similarly, if a person has named a proxy or health care agent in an advance directive, that person should also be given preference. This means that the guardian, conservator, proxy, or agent should be appointed SDM unless they aren't available or aren't willing to make a decision about neuroleptic medication.

Professional training. There is no legal requirement that the SDM be specially trained in medicine, pharmacology, mental health, psychology, law, social work, or any other professional discipline. After all, most people make important decisions about their own health care without being specially trained in medicine; they rely on information provided by their doctors or treatment providers and then use their own experience and common sense to make decisions whether or not to follow the doctor's recommendation.

The same is true here. It is enough that the SDM be able to understand information about the person's condition and the recommended treatment's benefits and risks, and to make a decision on the person's behalf. Of course, if you have professional training or experience, you should use that experience in making your decision, but you shouldn't feel inadequate if you don't have such training. Nevertheless, if you doubt your ability to understand this kind of information or to make a reasonable, objective decision, you should immediately inform the court of your concern and ask that someone else be appointed SDM.

Payment. An SDM may be paid by the court for his or her services. If payment is a concern for you, check it out with the court before accepting the appointment.

2. Gather information.

Next, you should begin to gather the information you will need to make a decision. Remember that, if treatment with neuroleptics is necessary, it is best for the treatment to begin promptly, so you should not waste any time in getting started.

There are two general kinds of information you should gather. First, you will want some background on the patient and the patient's medical condition; you can usually find this kind of information in the patient's medical records. Second, you will have to determine whether there is clear evidence of what the person would have chosen; to get this information, you will want to speak with the patient, and perhaps, others who know the patient.

a. Review the medical record for basic background and medical information.

At a minimum, you will certainly want to review the following information:

- date of and reasons for commitment
- the patient's diagnosis
- the patient's current symptoms
- the names of the treating physician and members of the treatment team
- the history of the patient's illness, if known
- the type of medication being prescribed, and the recommended dosage

Data privacy. As an SDM, you are entitled to obtain this information from the treatment program. *See* Minn. Stat. § 253.092, subd. 6(c). Remember, however, that you are given access to this information only to help you make your decision. You may not disclose it to anyone other than the staff at the facility providing the information who are assisting you in your decision-making. Nor may you disclose information to the patient's family or friends unless the patient has consented, in advance and in writing, to your doing to. Unless absolutely necessary, you should review the information directly at the facility and not make copies of it. This ensures that you won't accidentally misplace, lose or inadvertently disclose this sensitive information.

Neuroleptic Basis note. If the patient is in a state-operated treatment facility, the physician will probably have prepared a document called a "Neuroleptic Medication Authorization Basis Note". This document will summarize why the doctor thinks the patient is incapacitated, why neuroleptics are being prescribed, why other less-intrusive treatment won't work, and other pertinent information. A sample Basis Note form is in Appendix 4; different facilities may use different forms, but they should all contain the same information. If there is no basis note, you may wish to use the form in the appendix as the outline for your inquiry.

If there is a basis note, and you have any questions about the accuracy of the information, it is incomplete, or you don't understand what it says, you may want to look more closely at the records in the chart. Or you may ask the physician or treatment team to fill in the missing information. '

Once you have gathered this background information, you may be ready to interview the patient to determine what his or her wishes would be if he or she weren't too ill to make a decision.[1]

b. Try to determine the person's preferences.

Remember that, if the person ever made a "clear statement" of what the patient would decide in this situation when the patient had the capacity to decide, you must follow that statement, even if you personally don't believe it would be in the patient's best interests. Therefore, you should first determine whether there is evidence that the patient made a clear statement.

---

[1]You may choose to meet with the patient before you review the medical record if you wish. Some SDMs prefer to meet the patient in person first to form an impression that is not colored by the written record; others prefer to gain a deeper understanding of the patient's background before they meet the patient in-person in order to be sure they are asking the right questions. Use your best judgment.

Is there an advance directive? First, you should determine whether the patient has an advance directive. The facility should have asked the patient if there was an advance directive when the patient was admitted, and, if there is a directive, a copy should be in the chart. If there is no advance directive in the chart, check with the patient and any family or friends you may talk with to see whether they know if a directive exists. If there is a directive, you should look at it carefully to determine whether it is a clear statement of what the person would want. Generally, here is what you are looking for:

- Is there convincing evidence that the person had capacity when the advance directive was signed? Usually, there will be witnesses who sign the directive verifying that the person knew what he or she was doing, and this is usually good evidence that the person had capacity at the time. If there are no witnesses or other evidence, you may have a hard time determining whether the person had capacity at the time the directive was signed. The law states that the person is presumed to have capacity absent clear and convincing evidence to the contrary.

- Does the directive speak specifically to mental health treatment or treatment with neuroleptics, or is it more general? The more specific the directive is, the more likely it is a true reflection of the person's wishes at the time. If the statement is very general, you will have to decide whether it is "clear" that the patient wanted it followed with regard to neuroleptic medication.

- Is the directive consistent, or does it give conflicting directions? If the directions are clear and consistent, it is more likely that the person was capable of making a valid decision.

- How long ago was the directive signed? The older the directive is, the greater the likelihood that it isn't a true reflection of the person's wishes. This is especially true with neuroleptic medication because new kinds of neuroleptics may have been introduced that don't have the same risks as medications in use when the patient made the advance directive. If it is not clear that the person was aware of the newer medications, it may be unclear whether the directive really was intended to speak to the newer medication. Remember, however, that an advance directive should always be taken seriously as a potentially clear statement of the person's wishes unless you have good reason to doubt the person's capacity when he or she made it.

If, after reviewing the advance directive, you conclude that it was a clear statement of the person's wishes at a time when the person had the capacity to decide, the law says you must follow it.

What if there is no advance directive? Even if there isn't an advance directive, or the advance directive is ambiguous or of questionable validity, you may still be able to determine what the person would have chosen from other evidence that the person made oral or another kind of written statement to others expressing a preference. So long as you believe the person had capacity when the statements were made, you may rely on this as evidence of the person's wishes.

For example, you may determine that the person, while competent, generally accepted medical advice, in the past, and you may conclude that this behavior indicated a preference with

regard to neuroleptics as well. Similarly, the person may have lived his or her life in such a way that it would give you a good idea of what he or she would choose. For example, some religious communities forbid or discourage use of medicine, or favor using alternative modes of treatment. If the person is an active member of such a community, you may reasonably conclude that this is clear evidence of the person's wish not to take medication.

c. What if the patient's wishes can't be determined?

If you can't find clear evidence that the person expressed an opinion regarding treatment, or if there is conflicting evidence, you should make the decision that a reasonable person would make in the patient's position. You must consider the factors listed in the statute, including the patient's values, the risks and benefits of the treatment, and any special medical circumstances that suggest the treatment is or is not a good idea.

Treatment team. Often, you will have to rely on the person's treatment team for much of the information you will need, such as the risks and benefits of the particular medication being prescribed, the person's symptoms, etc. If you have any questions regarding the medical risks or benefits of the proposed treatment, you should ask the treatment team. You may also ask for a second opinion.

Side effects. Remember that, while there are some serious side-effects to neuroleptic medication for some persons, the medications are very helpful to most patients. If you are concerned about the potential side-effects, remember that a refusal to consent based on a fear of side-effects may result in the person remaining hospitalized for a long time. Your job is to balance the likelihood of those different results and decide as a reasonable person would do.

d. Meeting with the patient.

Even if there is an advance directive or other clear evidence of the person's wishes, you should arrange to meet with the patient in person to discuss the question of neuroleptics. The purpose of the meeting is at least threefold.

Involve the patient. First, you want to involve the patient in the decision-making process to whatever extent this is possible. Even if the patient is too ill to make the final decision him- or herself, the patient should at least be consulted and given the opportunity to participate to any extent possible.

Patient's values. Second, you should use the interview to determine what you can about the patient's values to help you determine what his or her choice would be if he or she were not ill at the moment. You may want to ask about the person's attitude towards medication in general. You may want to see whether he or she has religious, ethical, or cultural beliefs with regard to use of medication. You may also learn whether the patient has friends or family who could give you additional insight.

Refusal. Finally, you should determine whether the patient is refusing or will refuse medication. Generally, if the patient has been actively refusing, no SDM will be appointed. But you should check to be sure. Remember that your consent will be valid only as long as the patient is not refusing the medication. You should satisfy yourself that, if you consent, the patient will take the medication without being forced. You may explain to the patient that if he or she

does begin to refuse, treatment will be stopped, but could be started again if the facility obtains an order from the court authorizing treatment.

As noted above, it may sometimes be a close question as to whether a patient is refusing. In such a case, you can (1) try to negotiate with the patient to see if there is some reason for the refusal that can be overcome; (2) consent and let the treatment team determine whether the patient is actually refusing; or (3) decline to consent and tell the court why.

e. Meet with the patient's family or friends.

Although it is not required, it is sometimes a good idea to meet with the family or loved ones of the patient to see if they can give you additional information about the patient's values and likely preferences. This may not always be possible, but if it can be arranged in a timely manner it might give you additional insight in to the patient. Essentially, you are seeking the same kind of information about the patient as you were looking for in your meeting with the patient.

Remember, though, that the family member or friend may not always be putting the patient's interest first and may have a hostile relationship with the patient. If this is true, you should take this bias into consideration as you evaluate the information you receive. But many times family members will be excellent reporters of how the patient lived before being hospitalized and may give you a clearer idea of how the patient thought when well and what he or she would want to do now if he or she weren't ill.

Remember, too, that you may not share private information about the patient with the family member unless the patient has consented in writing to your doing so. Private information would include essentially anything you learn about the patient from the medical record or from the patient directly. You may tell the family member or friend that you have been appointed the patient's SDM and that you are seeking information to help you decide whether to consent to neuroleptic medication on the patient's behalf, but if asked for more information, you should tactfully respond that the law does not permit you to disclose information about the patient. You should then try to explain that you are asking for information from the family member or friend in order to help you make the best decision for the patient.

3. Make a decision whether to consent or not.

After you have gathered the necessary information, you should be ready to make a decision. When you are ready, you may tell the treatment staff your decision. If you consent to treatment, you will be asked to sign a consent form. The form will basically say that you have been appointed the patient's SDM, that you have been informed of the likely benefits and potential risks of the medication, and that you consent to the medication on the patient's behalf.

Unless you have good reason to do otherwise, you should give the treatment team flexibility to change the dosage and kind of neuroleptic used. If, however, the patient's non-refusal is based on receiving a certain medication, then you may limit your consent accordingly.

4. Report to the court.

When you have decided whether to sign a consent for treatment on the patient's behalf, you should report your decision to the court. A suggested form for such a report is included at

Appendix 5. The purpose of the report is to simply verify that you did the job the court asked you to do, and to confirm your decision. Provide a copy of the report to the patient, the patient's attorney, and the facility.

In addition, you may wish to write down, either in the report to the court or for your own records, who you talked to, what records you reviewed, and the factors you considered in making your decision. While this is not legally required, it may prove helpful to you later if you are asked to explain your decision. The law is clear that you cannot be held personally liable for the decision you make.

III. FREQUENTLY ASKED QUESTIONS.

Why does there have to be an SDM if the patient isn't refusing the medication? If the patient doesn't have the capacity to give informed consent, someone else with capacity must give consent on the patient's behalf; the decision cannot be left to the treatment team. The incapacitated patient's acquiescence with the treatment team's recommendation can't be considered "informed consent." It isn't "informed" because the patient can't understand the factual information about the medication, and it isn't "consent" because the acquiescence of an incapacitated person isn't really voluntary. Therefore, the law requires a third party to consent (or withhold consent) on the patient's behalf in, order to protect the patient from being unduly influenced by the treatment team.

You said earlier that an SDM may be used if the patient is committed, but my patient is on a hold order and hasn't had a commitment hearing yet. Should I have been appointed? Can I consent on the patient's behalf? Yes. For purposes of appointing an SDM, any one who is receiving treatment under the Commitment and Treatment Act (Minnesota Statutes chapter 253B) may have an SDM appointed. This includes persons on hold orders and those committed for "early intervention." Think of the hold order as a very short-term form of civil commitment. If the patient is hospitalized voluntarily, an SDM is not appropriate and should not be appointed. If, after being appointed, you learn that the patient is at the facility voluntarily (that is, not under compulsion of civil commitment or a hold order) then you should inform the treatment team that you cannot consent on the patient's behalf.

Who decides if the patient is incapacitated? Why isn't a hearing required first*?* The commitment law encourages the assessment of whether a patient needs neuroleptics and whether he or she has the capacity to consent early in the commitment process; this helps the patient to receive treatment promptly. Therefore, an SDM may be asked for when the commitment petition is filed if a court-appointed examiner or member of the treatment team informs the court that the patient may be incapacitated.

The court doesn't have to hold a hearing or decide right away whether the patient really is incapacitated because the patient's capacity will be promptly reviewed at the commitment hearing (or afterwards if the request for an SDM comes after commitment and the patient asks for a hearing). If the court finds the patient has capacity, the SDM can be discharged and the patient can make his or her own decision.

Moreover, if the patient has capacity, appointment of an SDM doesn't harm the patient. If the patient doesn't want treatment, the patient can simply refuse and will not be treated until the court determines, after a hearing, whether the patient has the capacity to refuse. But if the patient

with capacity is willing to accept treatment, and the SDM consents, no harm is done because the patient will receive the treatment he or she wants.

What if I think the patient has capacity? First, discuss your opinion with the treatment team. It may have additional information that may change your mind. Or, you may persuade the team that the patient has capacity and can make his or her own decision. If this happens, the team can get consent from the patient and you can inform the court of what happened.

If you and the team disagree as to whether the patient has capacity, you can do one of the following depending on whether or not the patient is refusing. If the patient is refusing medication, you should not consent, and in your report you may inform the court of your opinion as to the patient's capacity and the reasons for your opinion.

But if the patient is not refusing medication and you think the patient has capacity, you can either (1) consent (in which case the patient will be treated promptly on the basis of your consent) or (2) decline to consent and inform the court that you think the patient has capacity (in which case the patient may have to wait for the court to decide whether the patient has capacity before he or she can receive treatment).

The records say my patient has been receiving forced medication on an emergency basis without anyone's consent but now is willing to take the medication. How can this be? The law recognizes that a doctor may treat a person without informed consent in an emergency. The commitment law permits treatment in an emergency if "necessary to prevent serious, immediate physical harm to the patient or others." Minn. Stat. § 253B.092, subd. 3. Sometimes, a patient who receives treatment in an emergency gets better and will become willing to take the medication; in such a case, the SDM's consent may be appropriate. Sometimes, the emergency treatment will restore the person to capacity and the person can make his or her own decision.

The patient says he doesn't really want to take the medication but understands that he's unlikely to be discharged unless he does and says he will if I say so. May I consent on the patient's behalf? Yes, if you believe that the benefits of the medication outweigh the risks and that the patient will not have to be forced to take the medication. The patient's statement need not be considered a refusal because he is agreeing to take the medication if you consent on his behalf and no force will be necessary to administer the treatment. If the patient begins to resist the medication, then the facility will have to get a court order to continue treatment.

The patient's records indicate that she has had bad side effects from medication in the past. There is no advance directive or clear statement of what she would want under the circumstances. Should I consent? Yes, if you believe that a reasonable person would consent under the circumstances. Sometimes, this will require a decision based on how you balance the risks and severity of the side-effects versus the likelihood that the person will be able to be discharged from commitment. You should feel free to discuss with the treatment team whether the side effects can be ameliorated by other medication, or whether an alternative neuroleptic might have fewer or less-serious side effects. But ultimately, you may have to decide whether the side-effects are so bad that the patient should risk long-term commitment to the hospital. If the patient hasn't made a clear statement as to how she would balance the risks and benefits, you should do what you think a reasonable person would do.

What if I make a wrong decision? Can the patient sue me later if I consent and it turns out that there was a clear statement that I didn't know about, or if the medication harms the

person? The law says that a "substitute decision-maker who consents to treatment is not civilly or criminally liable for the performance of or the manner of performing the treatment." Minn. Stat. § 253B.092, subd. 9. It is a good idea to also keep a record of what records you reviewed, the persons you talked with, and the reasons for your decision. This will help you to defend the reasonableness of your decision should it be questioned.

What if I have more questions? If the question is about a legal matter, you may ask the court that appointed you for clarification. If you have medical questions, you should consult with the patient's treatment team, or you may seek independent advice from other psychiatric professionals. If you have questions about the patient's mental health history, his or her county case manager should be able to help. If you think the patient's rights are being violated, you may call the Ombudsman for Mental Health and Mental Retardation.

AG:200008, v.

APPENDICIES

253B.092 Standards and criteria for administration of neuroleptic medication; procedures.

Subdivision 1. **General.** Neuroleptic medications may be administered to patients subject to early intervention or civil commitment as mentally ill or mentally ill and dangerous only as provided in this section. For purposes of this section, "patient" includes a proposed patient who is the subject of a petition for early intervention or commitment.

Subd. 2. **Administration without judicial review.** Neuroleptic medications may be administered without judicial review in the following circumstances:

(1) the patient has the capacity to make an informed decision under subdivision 4;

(2) the patient does not have the present capacity to consent to the administration of neuroleptic medication, but prepared a health care directive under chapter 145C or a declaration under section 253B.03, subdivision 6d, requesting treatment or authorizing an agent or proxy to request treatment, and the agent or proxy has requested the treatment;

(3) a substitute decision-maker appointed by the court consents to the administration of the neuroleptic medication and the patient does not refuse administration of the medication; or

(4) the substitute decision-maker does not consent or the patient is refusing medication, and the patient is in an emergency situation.

Subd. 3. **Emergency administration.** A treating physician may administer neuroleptic medication to a patient who does not have capacity to make a decision regarding administration of the medication if the patient is in an emergency situation. Medication may be administered for so long as the emergency continues to exist, up to 14 days, if the treating physician determines that the medication is necessary to prevent serious, immediate physical harm to the patient or to others. If a request for authorization to administer medication is made to the court within the 14 days, the treating physician may continue the medication through the date of the first court hearing, if the emergency continues to exist. If the request for authorization to administer medication is made to the court in conjunction with a petition for commitment or early intervention and the court makes a determination at the preliminary hearing under section 253B.07, subdivision 7, that there is sufficient cause to continue the physician's order until the hearing under section 253B.08, the treating physician may continue the medication until that hearing, if the emergency continues to exist. The treatment facility shall document the emergency in the patient's medical record in specific behavioral terms.

Subd. 4. **Patients with capacity to make informed decision.** A patient who has the capacity to make an informed decision regarding the administration of neuroleptic medication may consent or refuse consent to administration of the medication. The informed consent of a patient must be in writing.

Subd. 5. **Determination of capacity.** (a) A patient is presumed to have capacity to make decisions regarding administration of neuroleptic medication.

(b) In determining a person's capacity to make decisions regarding the administration of neuroleptic medication, the court shall consider:

(1) whether the person demonstrates an awareness of the nature of the person's situation, including the reasons for hospitalization, and the possible consequences of refusing treatment with neuroleptic medications;

(2) whether the person demonstrates an understanding of treatment with neuroleptic medications and the risks, benefits, and alternatives; and

(3) whether the person communicates verbally or nonverbally a clear choice regarding treatment with neuroleptic medications that is a reasoned one not based on delusion, even though it may not be in the person's best interests.

Disagreement with the physician's recommendation is not evidence of an unreasonable decision.

Subd. 6. **Patients without capacity to make informed decision; substitute decision-maker.** (a) Upon request of any person, and upon a showing that administration of neuroleptic medications may be recommended and that the person may lack capacity to make decisions regarding the administration of neuroleptic medication, the court shall appoint a substitute decision-maker with authority to consent to the administration of neuroleptic medication as provided in this section. A hearing is not required for an appointment under this paragraph. The substitute decision-maker must be an individual or a community or institutional multidisciplinary panel designated by the local mental health authority. In appointing a substitute decision-maker, the court shall give preference to a guardian or conservator, proxy, or health care agent with authority to make health care decisions for the patient. The court may provide for the payment of a reasonable fee to the substitute decision-maker for services under this section or may appoint a volunteer.

(b) If the person's treating physician recommends treatment with neuroleptic medication, the substitute decision-maker may give or withhold consent to the administration of the medication, based on the standards under subdivision 7. If the substitute decision-maker gives informed consent to the treatment and the person does not refuse, the substitute decision-maker shall provide written consent to the treating physician and the medication may be administered. The substitute decision-maker shall also notify the court that consent has been given. If the substitute decision-maker refuses or withdraws consent or the person refuses the medication, neuroleptic medication may not be administered to the person without a court order or in an emergency.

(c) A substitute decision-maker appointed under this section has access to the relevant sections of the patient's health records on the past or present administration of medication. The designated agency or a person involved in the patient's physical or mental health care may disclose information to the substitute decision-maker for the sole purpose of performing the responsibilities under this section. The substitute decision-maker may not disclose health records obtained under this paragraph except to the extent necessary to carry out the duties under this section.

(d) At a hearing under section 253B.08, the petitioner has the burden of proving incapacity by a preponderance of the evidence. If a substitute decision-maker has been appointed by the court, the court shall make findings regarding the patient's capacity to make decisions regarding the administration of neuroleptic medications and affirm or reverse its appointment of a substitute decision-maker. If the court affirms the appointment of the substitute decision-maker, and if the substitute decision-maker has consented to the administration of the medication and the patient has not refused, the court shall make findings that the substitute decision-maker has consented and the treatment is authorized. If a substitute decision-maker has not yet been

appointed, upon request the court shall make findings regarding the patient's capacity and appoint a substitute decision-maker if appropriate.

(e) If an order for civil commitment or early intervention did not provide for the appointment of a substitute decision-maker or for the administration of neuroleptic medication, the treatment facility may later request the appointment of a substitute decision-maker upon a showing that administration of neuroleptic medications is recommended and that the person lacks capacity to make decisions regarding the administration of neuroleptic medications. A hearing is not required in order to administer the neuroleptic medication unless requested under subdivision 10 or if the substitute decision-maker withholds or refuses consent or the person refuses the medication.

(f) The substitute decision-maker's authority to consent to treatment lasts for the duration of the court's order of appointment or until modified by the court. If the substitute decision-maker withdraws consent or the patient refuses consent, neuroleptic medication may not be administered without a court order.

(g) If there is no hearing after the preliminary hearing, then the court shall, upon the request of any interested party, review the reasonableness of the substitute decision-maker's decision based on the standards under subdivision 7. The court shall enter an order upholding or reversing the decision within seven days.

Subd. 7. **Standards for making decisions regarding administration of neuroleptic medication.** (a) When a person lacks capacity to make decisions regarding the administration of neuroleptic medication, the substitute decision-maker or the court shall use the standards in this subdivision in making a decision regarding administration of the medication.

(b) If the person clearly stated what the person would choose to do in this situation when the person had the capacity to make a reasoned decision, the person's wishes must be followed. Evidence of the person's wishes may include written instruments, including a durable power of attorney for health care under chapter 145C or a declaration under section 253B.03, subdivision 6d.

(c) If evidence of the person's wishes regarding the administration of neuroleptic medications is conflicting or lacking, the decision must be based on what a reasonable person would do, taking into consideration:

(1) the person's family, community, moral, religious, and social values;

(2) the medical risks, benefits, and alternatives to the proposed treatment;

(3) past efficacy and any extenuating circumstances of past use of neuroleptic medications; and

(4) any other relevant factors.

Subd. 8. **Procedure when patient refuses medication.** (a) If the substitute decision-maker or the patient refuses to consent to treatment with neuroleptic medications, and absent an emergency as set forth in subdivision 3, neuroleptic medications may not be administered without a court order. Upon receiving a written request for a hearing, the court shall schedule the hearing within 14 days of the request. The matter may be heard as part of any other district court proceeding under this chapter. By agreement of the parties or for good cause shown, the court may extend the time of hearing an additional 30 days.

(b) The patient must be examined by a court examiner prior to the hearing. If the patient refuses to participate in an examination, the examiner may rely on the patient's medical records to reach an opinion as to the appropriateness of neuroleptic medication. The patient is entitled to counsel and a second examiner, if requested by the patient or patient's counsel.

(c) The court may base its decision on relevant and admissible evidence, including the testimony of a treating physician or other qualified physician, a member of the patient's treatment team, a court-appointed examiner, witness testimony, or the patient's medical records.

(d) If the court finds that the patient has the capacity to decide whether to take neuroleptic medication or that the patient lacks capacity to decide and the standards for making a decision to administer the medications under subdivision 7 are not met, the treating facility may not administer medication without the patient's informed written consent or without the declaration of an emergency, or until further review by the court.

(e) If the court finds that the patient lacks capacity to decide whether to take neuroleptic medication and has applied the standards set forth in subdivision 7, the court may authorize the treating facility and any other community or treatment facility to which the patient may be transferred or provisionally discharged, to involuntarily administer the medication to the patient. A copy of the order must be given to the patient, the patient's attorney, the county attorney, and the treatment facility. The treatment facility may not begin administration of the neuroleptic medication until it notifies the patient of the court's order authorizing the treatment.

(f) A finding of lack of capacity under this section must not be construed to determine the patient's competence for any other purpose.

(g) The court may authorize the administration of neuroleptic medication until the termination of a determinate commitment. If the patient is committed for an indeterminate period, the court may authorize treatment of neuroleptic medication for not more than two years, subject to the patient's right to petition the court for review of the order. The treatment facility must submit annual reports to the court, which shall provide copies to the patient and the respective attorneys.

(h) The court may limit the maximum dosage of neuroleptic medication that may be administered.

(i) If physical force is required to administer the neuroleptic medication, force may only take place in a treatment facility or therapeutic setting where the person's condition can be reassessed and appropriate medical staff are available.

Subd. 9. **Immunity.** A substitute decision-maker who consents to treatment is not civilly or criminally liable for the performance of or the manner of performing the treatment. A person is not liable for performing treatment without consent if the substitute decision-maker has given written consent. This provision does not affect any other liability that may result from the manner in which the treatment is performed.

Subd. 10. **Review.** A patient or other person may petition the court under section 253B.17 for review of any determination under this section or for a decision regarding the administration of neuroleptic medications, appointment of a substitute decision-maker, or the patient's capacity to make decisions regarding administration of neuroleptic medications.

HIST: 1997 c 217 art 1 s 60; 1998 c 313 s 8,9; 1998 c 399 s 30,31

ANTIPSYCHOTICS

Brand Name	Generic Name
Clozaril	clozapine
Compazine	prochlorperazine
Haldol	haloperidol
Haldol Decanoate	haloperidol decanote
Loxitane	loxapine
Moban	molindone
Mellaril	thioridazine
Navane	thiothixene
Orap	pimozide
Prolixin	fluphenazine
Prolixin Decanate	fluphenazine decanoate
Risperdal	risperidone
Serentil	mesoridazine
Seroquel ,	quetiapine
Stelazine	trifluoperazine
Thorazine	chlorpromazine
Zyprexa	olanzapine

* - reference: Physician Desk Reference, 53rd Edition, 1999

Antipsychotics 7/12/99

STATE OF MINNESOTA DISTRICT COURT
COUNTY OF _____ _____JUDICIAL
DISTRICT

Case type: other Civil-
Mental Health
In the Matter of AFFIDAVIT OF

_____ _____
(Patient) (Medical Expert)

STATE OF MINNESOTA)
COUNTY OF _____)

_____, being first duly sworn, states as follows:

1. My educational background, training, and experience include the following: See Exhibit A hereby incorporated by reference.

2. I am qualified to give background information about the effectiveness and usage of neuroleptic medication.

DEFINITION OF NEUROLEPTIC MEDICATION

3. Psychosis is a term that signifies a gross impairment in the perception of reality, with symptoms that may include delusions and hallucinations. Neuroleptic (sometimes referred to as antipsychotic) medications improve mental functioning through a decrease in the psychotic symptoms of mental illness, including psychotic thinking, distorted perceptions, emotional disturbance, and pathological behaviors. Neuroleptic medications are a subclass of psychotropic medications.

4. Neuroleptic medications are separate, different, and distinct from other classes of psychotropic medications such as sedative-hypnotics, anti-anxiety agents, ("minor tranquilizers"), or antidepressants. These latter medications have no practical antipsychotic effects in that they do not affect the core symptoms of the illness, and are not acceptable substitutes for neuroleptics in the treatment of psychosis.

5. Neuroleptic medications are those medications that are approved by the Food and Drug Administration (FDA) for the treatment of the psychotic symptoms of mental disorder(s). There are several major chemical classes of neuroleptic medications. Although these medications differ chemically, they all have the unique pharmacologic property of alleviating psychotic symptoms of mental illnesses. Within the individual classes of medications there may be differences in the efficacy and side effects experienced by the individual.

6. Most neuroleptic medications can be administered orally or by intramuscular injection. Oral forms include liquid concentrates, tablets, or capsules in several strengths. Some

medications are available only in oral form. Two neuroleptic medications, Haldol Decanoate and Prolimn Decanoate, are administered by a long-acting intramuscular injection.

EFFECTIVENESS OF NEUROLEPTIC MEDICATIONS

7. Neuroleptic medications have been studied widely since the introduction of Chlorpromazine (Thorazine) in 1952. These studies demonstrate that neuroleptics reduce psychotic thought processes, reduce and sometimes eliminate hallucinations and delusional thought systems, and restore rational thought processes. Relief of these symptoms alleviates the patient's distress, prevents the appearance of new symptoms, makes the patient more amenable to psychosocial interventions, and restores mental competence.

8. Some persons with mental illnesses do not respond completely to neuroleptic medication and therefore remain chronically and seriously mentally ill. Neuroleptic medications may nevertheless benefit these partial responders by reducing the severity of their symptoms and improving their psychosocial functioning. Neuroleptic medications may also help prevent patients from harming themselves or others by alleviating the symptoms of mental illness that provoke aggression or self-harm, even if they do not eliminate all the symptoms of the illness.

9. The exact mechanism of action of neuroleptic medications is unknown. Research suggest that neuroleptic medications work by affecting the ability of the brain to sort out and integrate perceptions and thoughts. Psychotic episodes are presumed to be caused by an imbalance among multiple biochemical systems in the brain. Neuroleptic medications influence the effects of these biochemical systems.

10. Many factors are involved in mental illnesses. These include biochemical systems, genetic, psychological, and social factors. The comprehensive management of mental illness combines neuroleptic medications and other forms of treatment. Neuroleptic medications often allow the patient to benefit from other forms of treatment, including behavioral therapy, social skills training, individual psychotherapy, and family therapy.

11. Neuroleptic medications do not cure mental illness. Rather, they eliminate or reduce the symptoms of mental illness. Studies show that discontinuance of neuroleptic medication often causes a relapse of the illness. About 50 percent of patients who stop taking neuroleptic medication suffer a relapse of their illness within six months. The comparable rate of relapse for patients who continue to take neuroleptic medications is only about 15 percent.

12. In the past, neuroleptic medications were frequently called "major tranquilizers". This characterization is pharmacologically inaccurate, since their primary effect is to normalize mental functioning, not tranquilize or sedate. Neither do neuroleptic medications change personality or affect character traits, beliefs, or values. It is therefore inaccurate to call properly administered neuroleptic medications "mind controlling", "mind altering", or "thought-inhibiting".

13. In Minnesota and the United States, neuroleptic medication, alone or with other medication, is the treatment of choice for psychotic symptoms of mental illness. Neuroleptic medications that have been approved by the Federal Food and Drug Administration (FDA) are not experimental.

INDICATIONS FOR NEUROLEPTIC MEDICATION

14. The primary indication for treatment with neuroleptic medication is the presence of a mental illness with psychotic symptoms.

15. In choosing a particular neuroleptic medication to administer to a patient who has previously been treated with neuroleptic medication, the following factors are considered: the patient's past response to neuroleptic medication, the patient's past experience with side effects from neuroleptic medications, and the patient's history of compliance with the administration of neuroleptic medications, and the patient's history of relapse without neuroleptic medication.

16. Patients vary in their response to neuroleptic medications. Different patients may need different dosages of a particular neuroleptic medication due to differences in the rate at which they absorb and metabolize the medication. Some patients may need a high dosage of a neuroleptic medication because of poor individual response, severe symptoms, or other factors which reduce the effectiveness of the medication. It is important to provide adequate dosages of neuroleptic medication in order to treat an acute psychotic episode effectively. Inadequate dosages tend to prolong the episode and the patient's hospital stay, and may expose the patient to the risks of neuroleptic medication without offering adequate chance for benefit. These multiple clinical variables require flexible medication dosing and medication selection.

DURATION OF TREATMENT WITH NEUROLEPTIC MEDICATION

17. The duration of treatment with neuroleptic medication generally is determined by evaluating the benefits and the risks of the treatment. Some patients who are treated with neuroleptic medication have only brief psychotic episodes. In these cases, the medication should be stopped as soon as clinically indicated. Most patients need to take neuroleptic medication for at least several months after remission of their first psychotic episode. Patients with chronic and serious mental illness ordinarily require continuous treatment with neuroleptic, medication, even during periods of remission. Where there is evidence of substantial benefit, even if there is not complete remission of symptoms, the long-term benefits of continued treatment usually outweigh the risk of the development of other side effects in patients with chronic and serious mental illness.

SIDE EFFECTS OF TYPICAL (TRADITIONAL) AND ATYPICAL NEUROLEPTIC MEDICATIONS

A. Typical Neuroleptics

18. The more common temporary and acute side effects of neuroleptic medications are divided into categories entitled anticholinergic effects, extrapyramidal effects, sedative effects, and hypotensive (low blood pressure), effects.

19. Anticholinergic effects include blurred vision, dry mouth, constipation, urinary retention, temporary impotence, menstrual irregularities, skin rash, increased or decreased perspiration, and rapid heart beat. Elderly patients with pre-existing organic impairment may develop memory deficits, confusion, or delirium due to the anticholinergic effect of some neuroleptics.

20. Extrapyramidal side effects, also called EPSE, are characterized by tremor, rigidity, and slowness of movement. Akathisia, dyskinesia, and dystonic reactions may also occur. Akasthisia is a subjective feeling of restlessness. Dyskinesia is involuntary, repetitive purposeless movement of muscles. Dystonic reactions are muscle spasms, usually of the neck, jaw, and tongue.

21. It is not possible to predict with accuracy whether a particular neuroleptic medication will produce any side effects, or which side effects will be produced, although some side effects are more common to one medication than another. Numerous non-neuroleptic medications are available to ease the discomfort of side effects from the neuroleptic medications. If a patient's side effects prove troublesome with a particular neuroleptic, a physician may elect to adjust the dose or to switch to another neuroleptic medication. Most side effects are reversible and usually disappear upon discontinuation of the particular neuroleptic medication.

22. Tardive dyskinesia is a chronic form of dyskinesia. This syndrome of involuntary, repetitive, purposeless movements of the oral, facial, limb, and truncal musculature may occur after prolonged treatment with neuroleptic medication. The severity of tardive dyskinesia ranges from mild and inconspicuous to severe and disfiguring.

23. Tardive dyskinesia commonly occurs after long-term treatment with neuroleptic medication, usually with high doses. In persons treated with neuroleptic medication for more than ten years, the incidence of at least mild symptoms is estimated at 20 to 40 percent. The elderly population may be at higher risk of developing tardive dyskinesia after a shorter period of exposure to neuroleptic medications or with lower dosages.

24. Patients receiving neuroleptic medication are monitored carefully for signs of tardive dyskinesia. Patients with severe psychotic symptoms may need to continue to take neuroleptic medication in spite of the development of tardive dyskinesia. The decision to continue treatment with neuroleptic medication when tardive dyskinesia is present is based on clinical judgement. Discontinuation of neuroleptic medication may be the appropriate response to tardive dyskinesia. However, in some cases, if no effective alternative treatment for the mental illness is available, the benefits of treatment with neuroleptic medication often continue to outweigh the risks. Patients who develop tardive dyskinesia and who continue to take neuroleptic medications may receive at least partial relief of their dyskinesia symptoms through the use of other medications

25. Neuroleptic malignant syndrome, (NMS), is a rare and potentially life threatening complication of treatment with neuroleptic medication. NMS occurs in less than one-tenth of one percent of patients treated with neuroleptic medication. Symptoms include high fever, severe muscular rigidity, high blood pressure, delirium, and other medical complications. With prompt recognition and treatment, NMS is usually reversible and will not likely recur, even if the same patient is later treated with the same neuroleptic.

26. Typical neuroleptic medications can be loosely grouped into 3 categories. These include "low potency", "medium potency", and *"high* potency".

a) Low potency neuroleptic medications include Chlorpromazine, (Thorazine), Thioridazine, (Mellaril), and Mesoridazine, (Serentil). Their main side effects may include anticholinergic symptoms, such as dry mouth, constipation, blurred vision,

urinary retention, and confusion. These side effects are minimized with other medications and non-drug therapies.

b) Medium potency neuroleptic medications include Loxapine, (Loxitane), Molindone, (Moban), Trifluoperazine, (Stelazine); and Thiothixene, (Navane). Their side effect profile includes a mixture of anticholinergic and extrapyramidal symptoms.

c) High potency neuroleptic medications include Haloperidol, (Haldol), and Fluphenazine, (Prolixin). Their main side effects may include extrapyramidal symptom effects such as: stiffness, tremors, slowed movements, Off difficulty walking, unstable balance, drooling, muscle spasm of the jaw, neck, eyes, and back, and a general feeling of restlessness or a feeling of being "ill at ease". These side effects are minimized with other medications.

B. Atypical Neuroleptic Medications

27. The term "atypical" refers to neuroleptic medications that do not possess the typical side effect profile of the traditional agents. They have substantially lower incidence of tardive dyskinesia and EPSE. All neuroleptic medications introduced since 1990 are atypical, in this sense.

28. Clozapine, (Clozaril) was approved by the FDA in 1990. Clozapine's side effects may include sedation, orthostatic hypotension, temperature elevation, or hypersalivation. An uncommon, but potentially life threatening side effect of Clozapine is suppression of white blood cell production. Patients on Clozapine therapy have their white blood cell (WBC) counts monitored frequently.

29. Risperidone, (Risperdal) was approved by the FDA in 1994. It has relatively few side effects. Risperidone's side effects may include orthostatic hypotension, dizziness, and tachycardia. Somnolence, extrapyramidal symptoms, constipation, nausea, dyspepsia, and rhinitis have also been reported by some patients.

30. Olanzapine, (Zyprexa), was approved by the FDA in 1996. It has relatively few side effects. Olanzapine's side effects may include dizziness, drowsiness, restlessness, and weight gain.

31. Quetiapine, (Seroquel), was approved by the FDA in 1997. It has relatively few side effects. Quetiapine's side effects may include orthostatic hypotension, headache, somnolence, dizziness, dry mouth, abdominal pain, or weight gain. The occurrence of extrapyramidal effects is extremely rare with Quetiapine. It is believed that the incidence of tardive dyskinesia is minimal if present at all when compared to Haloperidol.

Patient's Legal Status: □ Voluntary □ Emergency Hold Order □ Court Hold
□ Committed as_____

1. Briefly describe the patient's clinical condition which supports a recommendation for treatment with a neuroleptic medication:_____

2. List the working diagnoses of the condition for which neuroleptic medication treatment is being recommended:_____

3. Is the treatment of choice in prevailing medical practice an neuroleptic medication?
□ Yes □ No

4. Treatment options:_____

5. Medication ordered:_____

6. If only oral use of neuroleptic medication is proposed, will forced administration by nasogastric tube possibly occur? □ Yes □ No

7. Document the propose course of treatment with neuroleptic medication (How the medication will be prescribed, monitored, and adjusted):_____

8. Possible risks and side effects and what can be done if these occur:_____

9. Indicate likely benefits and outcomes for the patient after treatment with neuroleptic medication:_____

If you ask, we will give you this information in another Form, such as Braille, large print or audiotape.

DHS- 3339 (1-98)
Side 1

Original: Medical Record

Facility Name:

Patient Name:
MREC #:
Birthdate:
Sex:
Program/Unit:

NEUROLEPTIC MEDICATION AUTHORIZATION BASIS NOTE

10. Prognosis if neuroleptic medications are not administered:_____

11. Identify neuroleptic medications that have been administered in the past, and past response, including side effects:_____

12. **FOR EMERGENCY ONLY:** Describe the rationale for the decision to treat the patient with neuroleptic medications to prevent serious, immediate physical harm to the patient or to others. Documentation of the emergency must be in specific behavioral terms.

13. Determination of patient's capacity requires that all three components be present:

a. Does the patient demonstrate awareness of the nature of the patient's situation, including the reasons for hospitalization and possible consequences of refusing treatment with neuroleptic medication.

☐ Yes ☐ No

b. Does the patient demonstrate an understanding of treatment with neuroleptic medications and the risks and benefits of and alternatives to such treatment.

☐ Yes ☐ No

C. Does the patient communicate verbally or non-verbally a clear choice regarding treatment that is reasoned and not delusional, even though the choice may not be in the patient's best interest.

☐ Yes ☐ No

Disagreement with the physician's recommendation' must not be cited as evidence of an unreasonable decision.

Document the specific reasons which lead to the determination of the patient's capacity.

Physician's Signature	Date & Time
Print Name	

DHS-3339 (1-98)
SIDE 2

Facility Name:
Patient Name:
MREC #:
Birthdate:
Sex:
Program/Unit:

SAMPLE REPORT OF SUBSTTI'UTE DECISION-MAKER

STATE OF MINNESOTA DISTRICT COURT

COUNTY OF _____ JUDICIAL DISTRICT

In the Matter of: Court File No._____

_____ , REPORT OF SUBSTITUTE DECISION-MAKER

Respondent,

Alleged _____ .

As required by the order of the Court appointing the undersigned to be the Substitute Decision-Maker for the respondent with authority to consent to the administration of neuroleptic medication, the undersigned reports as follows:

(CIRCLE CORRECT RESPONSE TO EACH ITEM)

1. The respondent's treating physician **DOES / DOES NOT** continue to recommend treatment with neuroleptic medication.

2. As Substitute Decision-Maker, **I HAVE GIVEN / HAVE WITHELD** consent to such treatment on behalf of the respondent.

3. The respondent **ACCEPTS / REFUSES** such treatment.

(ADDITIONAL RELEVANT INFORMATION MAY BE ATTACHED)

Dated: _____ _____

Substitute Decision-Maker

AG:115985 v1