Advising Clients & Drafting Advanced Health Care Directives

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I. Effective Planning Techniques for Incapacity

A. Why is planning for incapacity important?

With the increasing numbers of Americans that are living longer, and with ability for medical technology to prolong life, it is particularly important that people plan for mental or physical incapacity in the future. The emphasis on planning should be placed on all of your clients, regardless of age, health status and family medical history. Here are some reasons why planning for incapacity is important:

- The average life expectancy in the U.S. continues to rise due to improvements in science, and health care.[1]
- Approximately 34 to 43 million people in the United States have chronic disabilities.[2]
- Quality of life and end of life issues are a priority for potential clients. People are willing to flight for access to proper care.
- In 2000, 35 million Americans, 12.4 percent of the total U.S. population were 65 or older. By 2030, nearly 70 million will be 65 or older.[3]
- Approximately 10 percent of people 65 and older have at least one chronic condition and many more have multiple conditions.
- Currently, there are approximately 4.5 million people with AD; doubling since 1980. By 2050, numbers could range from 11.3 million to 16 million. 1 in 10 Americans had a family member with AD; 1 in 3 knew someone with the disease[4]

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[1] Practical Aspects of Managing an Elder Law Practice by Robert Fleming; Elder Law Portfolio Series, Aspen Publishing, quoting: Aging America: Trends and Projections, U.S. Senate Special Committee on Aging.

[2] *See Disability Outcomes and Prevention* from the National Center for Injury Prevention and Control of the Centers for Disease Control at http://www.cdc.gov/ncipc/didop/disability.htm (last viewed April 15, 2005).

[3] ICLE Advising the Older Client, Chapter One, Developing an Elder Practice quoting: A profile of Older Americans by AARP, 2001.

[4] See *Fact Sheet: About Alzheimer's Disease Statistics* from the Alzheimer's Association at http://www.alz.org/Resources/FactSheets/FSAlzheimerStats.pdf. Visited April 15, 2005.

Thus, the chances of an individual of becoming incapacitated and unable to participate in the decision-making process in all aspects of his or her life is becoming significantly greater. This is a legal issue that could potentially impact each of us, and all of our clients.

B. Planning in Advance. Consider these options when discussing the issue with your clients:

1. Powers of Attorney

A power of attorney is a means by which a person (the principal) confers legal authority to act on his or her behalf to another party (the agent). The agent has those powers that are delegated in the power of attorney and typically relate to assisting the principal with managing the principal's financial and legal affairs. The powers may be broad or very specific. For example, an agent's powers may include representing the principal's interests with a school district, service provider, or financial institution. An agent's authority to act under a power of attorney terminates if the principal terminates the relationship or if the principal dies or becomes incapacitated. The *durable* power of attorney, as authorized by statute, differs from the *general* power of attorney in that it authorizes the agent to act for the principal even after the principal becomes incapacitated. Therefore, a durable power of attorney is preferred when the client wishes to plan for incapacity to protect against the possible future need of a court-appointed guardian or conservator. This is an issue that resonates with clients. If they do not want to force probate court involvement in their business in the event they become disabled, then they need to take steps to minimize the need for a guardian or conservator.

The statutory requirements for a durable power of attorney are that it be in writing and that the contain words showing the principal's intent that the agency's authority granted by the durable power of attorney continue notwithstanding the principal's later disability or incapacity. MCL 700.5501. In order to be considered competent to execute a power of attorney, the principal must be able to consent to and render a degree of control over the agency relationship. Public policy interests are served by the requirement that the principal have the ability to engage in thoughtful deliberation and use reasonable judgment regarding formation, or risk abuse/coercion by the Agent. See, for example, *Persinger v. Holst*, 248 Mich. App. 499, 505, 639 N.W.2d 594 (2002).

Some considerations when planning for incapacity when drafting a durable power of attorney include:

- *Springing vs. immediately effective*. Often, a durable power of attorney is drafted to provide "springing" powers, whereby the Agent's authority to act on behalf of the Principal does not become effective until it is determined that the individual is incapacitated. However, when planning for incapacity, particularly for individuals who have a greater potential to become incapacitated (*e.g.*, individuals in the initial stages of progressive dementia, MS, etc.), the principal may wish to make the powers to assist the individuals effective immediately.

- *Provision for residence and care*. As noted below, Michigan requires that a durable power of attorney for health care, or a patient advocate designation, become effective only through "springing" powers. This means the agent may only make medical decisions on the principal's behalf upon the principal's incapacity. However, it is often recommended that the agent in the power of attorney be provided powers to assist with residence and general health care issues, as some clients may simply wish to for an agent to assist with such matters prior to reaching

a level of incapacity to make medical decisions. For example, language such as this may be included in the document:

> ***Residence and Care***. *My Agent may determine my place of residence from time to time, pay my ordinary household expenses, arrange for and pay the costs of medical, dental, nursing, hospital, convalescent and other health care and treatment, including admission to hospitals, nursing homes, rest homes or other care facilities or institutions; consent to treatment, and make application for insurance, pension or employee benefits related to such health care and treatment, including, but not limited to, benefits under Social Security, Medicare and Medicaid. My Agent may obtain on my behalf copies of medical reports, summaries or other related information concerning me made or taken before or after the date of this instrument, including, but not limited to, records and/or communications, and execute any written consents on my behalf for the disclosure of such records and communications to such persons or entities as my Agent deems appropriate. My Agent and my Patient Advocate each shall be considered my "personal representative" for purposes of the privacy rule issued by the U.S. Department of Health and Human Services and required by the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164, as from time to time amended ("HIPAA"). If there is any conflict between this document and my Patient Advocate Designation, my Patient Advocate Designation shall be primary.*

- *Gifting and financial planning powers for long term care.* Because a growing number of people with disabilities need to obtain government benefits to pay for their long term care, it is important when planning for incapacity that the power to gift and transfer assets are granted to the agent in order to assist the principal in obtaining eligibility for public benefits such as Medicaid. Many powers of attorney do not permit gifting powers or limit it due to power of appointment concerns. If so, this could trigger the need for a protective order if Medicaid planning becomes an issue in the future. The estate size and family dynamics will need to be considered when addressing this with your clients.

- *HIPAA language to determine incapacity of the principal and agent*. If your client wishes to grant "springing" powers to the agent, then language should be included addressing the Privacy Rules of the Heath Insurance Portability and Accountability Act of 1996 (HIPAA) to authorize disclosure of health information to the agent regarding medical conditions that may affect the capacity of the principal to make medical decisions. In addition, typically an individual will nominate a successor agent if, in part, the initial agent is unable to perform his/her duties due to incapacity. Thus, language should also be included to authorize the successor agent(s) to obtain relevant health information to determine the capacity of the primary agent to perform their duties. I often include this language in the Agent's "Acceptance" form.

2. Patient Advocate Designations for Medical Decisions and Lessons from Terry Schiavo

The years of conflict around Terri Schiavo's situation was a tragedy for her whole family, yet they have educated us about ourselves and forced us to ponder very controversial issues regarding end of life treatment, the value and quality of life, the right to make our own medical decisions and the preservation of self-determination, and the ability to ensure our wishes are followed regarding end-of-life treatment when we can no longer speak for ourselves.

As you know by now, Terri Schiavo suffered a cardiac arrest, which resulted in brain damage from insufficient oxygen to the brain in 1990. At that time, Terri had not executed any document such as a living will that expressed her preferences regarding life-sustaining treatment. A feeding and hydration tube was inserted as a result of the severe brain damage due to her inability to swallow or eat or drink. Her husband, Michael Schiavo, was appointed guardian later that year. Terri then received extensive treatment and rehabilitation through 1994.

In 1998, her husband finally petitioned the court to authorize the removal of Terri's feeding and hydration tube, asserting that Terri would have wanted it that way. A guardian ad litem was appointed to review the case and represent Terri's interests, and concluded that Terri was in a "persistant vegetative state" with no chance of improvement.[5] The judge also concluded that there was clear and convincing evidence that Terri would have wanted the tube removed upon the review of statements she made to her husband and other evidence. Terri's parents and siblings disputed the fact that she wanted the tube removed, as well as Terri's condition being described as a "persistent vegetative state," and whether there were available medical treatments to improve Terri's condition.

From that point, there was an explosion of litigation between Terri's husband and her parents surrounding whether the feeding and hydration tube should be removed. The matter also led to extensive involvement by Jeb Bush, the Florida legislature, the U.S. Congress and President Bush. Numerous moral and legal arguments were raised regarding to involvement of government institutions and courts in an extremely personal matter, how religious values affect our society, and the preservation of life. Nevertheless, at minimum, the Schiavo case provides a good example and reminder for all of us why it is important that we plan for incapacity, no matter how young we are, or our health status, through identifying *who* we want to make medical decisions on our behalf, and what our preferences are regarding medical decisions and life-sustaining treatment.

Federal law regarding self-determination and end of life decision-making

The first case to address end-of-life decision-making by the state's highest court was *In re Quinlan*, 70 NJ 10, 355 A.2d 647 (1976), where the New Jersey Supreme Court held that the right to make medical treatment decisions, including right to refuse or withdraw med treatment, is a constitutional right to privacy. The U.S. Supreme Court later confirmed this in *Cruzan v. Missouri Department of Health*, 497 US 261 (1990), and affirmed that there is a constitutionally protected right to withhold or withdraw life support, and that food and hydration was considered "medical treatment." As a result of

[5] To view the guardian ad litem report by Richard L. Pearse, Esq. in full, see http://www.miami.edu/ethics2/schiavo/122998%20Schiavo%20Richard%20Pearse%20GAL%20report.pdf

Cruzan, the Federal Patient Self-Determination act was passed, providing legal recognition of our Constitutional right to self-determination and medical decision-making, including the use of advanced directives whereby an individual may state their wishes regarding medical treatment to ensure they are followed should they become incapacitated.

Medical and Life-Sustaining Treatment Decisions in Michigan.

If there is no "advanced directive," Michigan law will allow another person to make medical decisions on behalf of an individual, also referred to as "substituted decision-making." The relevant case is *In re Martin*, 450 Mich 204 (1995), with facts remarkably similar to the Schiavo case, the court held that a surrogate decision-maker may order life-sustaining treatment withheld or withdrawn only when it is clear that particular person would have refused treatment under those *exact* circumstances or circumstances highly similarly to current situation involved. Otherwise, the State's interest in preserving life prohibits withdrawal of life-sustaining treatment if there is no clear and convincing evidence of the individual's preferences. In *In re Martin*, the court determined that the statement made by the individual in response to a television program that he would not want to live like a vegetable was **NOT** clear and convincing evidence to support the removal of a feeding tube after an accident that left him completely paralyzed, unable to talk, eat or drink. Thus, there is a fairly high standard of proof required before someone can decide to withdraw life-sustaining treatment on another individual's behalf. That makes it particularly important that individuals take the proper steps to minimize the chances that a scenario such as Terri's and Mr. Martin's will not happen to them.

In 1990, the Michigan legislature authorized a durable power of attorney for health care. MCL 700.5506. The statute states, "[a] person 18 years of age or older who is of sound mind at the time a designation is made may designate in writing a person who is 18 years of age or older to exercise powers concerning care, custody, and medical treatment decisions for the person who made the designation…. [A] person who is named in a designation…shall be known as a patient advocate and a person who makes a designation shall be known as a patient." Id.

It is important to note that the patient must be of "sound mind." Id. This is the same standard as seen in the realm of last wills and testaments. In order to execute a will, "[a]verage mental capacity at the time of the execution of the will is not necessary to its validity. A less degree of mind or capacity is requisite to execute a will than to make a contract covering the same subject matter." Bean v Bean, 144 Mich 599, 108 NW 369 (1906); see also, Rivard v Rivard, 109 Mich 98, 66 NW 681 (1896). The Michigan Supreme Court, in determining whether a person was of sound mind, has stated "[t]he weak have the same right as the prudent and strong minded to dispose of their property." In re Getchell's Estate, 295 Mich 681, 295 NW 360 (1940). Presumably this principle holds true for decisions concerning a person's health as well.

The patient advocate's powers spring into place when the patient, "is unable to participate in medical treatment decisions." MCL 700.496(8). The statute allows for the filing of a petition in probate court to resolve disputes that may arise over whether the person is able to participate in medical treatment decisions. Id. Practitioners must realize that there is a difference between the ability to give informed consent and the ability to participate in treatment decisions. Further, the ability to participate, however cursory (e.g.

ask simple questions), could bar an agent's involvement in the medical decision-making process.

It should be added that a person eighteen years or older, who is of sound mind, or their Durable Power of Attorney for Health Care can execute a Do Not Resuscitate Order. (The statutory form is required and it must be signed by the person's attending physician and two witnesses, at least one of which is not a spouse, child, grandchild, sibling or presumptive heir). Michigan licensing requirements may still require direct care staff to contact medical services if a resident suffers a cardiac arrest. However, when the emergency medical personnel arrive, they may follow the Do Not Resuscitate Order. In particular, the Patient Advocate must take "reasonable steps to follow the desires, instructions, or guidelines given by the patient while the patient was able to participate in care, custody, or medical treatment decisions, whether given orally or as written in the designation." *Id.* Furthermore, the law states that if the *Patient Advocate Designation* and the authorization of Patient Advocate to make decisions regarding life-sustaining treatment is "clear and convincing," then the Patient Advocate may make such decisions for that individual. *Id.* This may be set for in the actual document, or, in more detail, in a supplemental document such as the *Health Care Values History Form*, **Appendix One**.

The Patient Advocate form should be made available to all health care providers involved with your medical treatment, family members, and friends. The Patient Advocate Designation form can be found at various websites, as well as health care providers. However, it is beneficial for an attorney to assist with the drafting of the Patient Advocate Designation to ensure not only that the document meets the legal requirements, but that it clearly expresses the individual's wishes.[6]

Additional Resources:

- For a *Durable Power of Attorney for Health Care/Patient Advocate Designation* form from the State Bar of Michigan, see http://www.michbar.org/elderlaw/pdfs/dpoa_hc.pdf
- For a brochure on *Planning for Medical Decision-Making* from the National Academy of Elder Law Attorneys, see http://www.naela.org/Applications/News-app/Files/MedicalDecisionMaking.pdf
- For the form *Clear and Convincing Evidence of Your Wishes*: http://www.agingwithdignity.org/5wishes.html
- National Right to Life website: http://nrlc.org
- For information regarding *Docubank* – an electronic storage and access service for advanced directives: http://www.docubank.com
- For a comprehensive timeline and summary of events of the Schiavo case, see: http://www.miami.edu/ethics2/schiavo/timeline.htm

[6] *The authors acknowledge the scope of this article does not address end-of-life decision-making for people who are not considered competent in the eyes of the law to express their wishes (i.e., minors, or persons born with significant challenges).*

- See *Washington Watch*, Vol 3 Issue 3, for a good summary of the history and perspectives of the disability community: http://www.aamr.org/ww/WW_%20Vol3_Issue%202.pdf

3. Patient Advocate Designation for Mental Health Treatment

There have been recent developments in the law that will have a significant impact on persons receiving mental health treatment as well as planning for those who may experience a need for mental health treatment. As you may have heard, Michigan legislature recently passed Kevin's Law, whereby probate courts are now authorized to order assisted outpatient treatment. In response to the more intrusive and restrictive nature of Kevin's Law and to protect the ability of individuals with mental illness to plan for their own incapacity, legislation was passed in response to Kevin's Law to allow for a designation of an agent to make mental health treatment decisions on the principal's behalf.

a. Kevin's Law

Kevin's Law allows the probate courts to order "assisted outpatient treatment" (herein referred to as "AOT") for a person with mental illness *without* having to demonstrate that the individual posed a danger to himself or others, which is the standard that was used by courts to order inpatient psychiatric hospitalization for persons with mental illness. Thus, this legislation, added to the Michigan Mental Health Code, gives Judges the ability to order involuntary *outpatient* treatment under specific circumstances. It is important to note that this did not change MCL 330.1208, which defines individuals with "serious mental illness" as one of the three groups of individuals for which priority shall be given by the Community Mental Health Services Program.

Kevin's Law was introduced in response to the brutal beating of Kevin Heisinger, a University of Michigan student, by a man with mental illness in 2000 in the men's room of the Kalamzoo Amtrack and bus station. The man with mental illness had been diagnosed with schizophrenia and a history of medication non-compliance.

"Person requiring treatment"

According to the new legislation, AOT can be ordered by a court if the following requirements are met:

1. Person has a mental illness;
2. Is unable to understand the need for treatment due to impairments, and is unlikely to participate in treatment voluntarily;
3. Intervention is necessary to avoid a relapse or harmful deterioration of his/her condition;
4. Is currently noncompliant with treatment recommended by a mental health professional; **and**,
5. The noncompliance with treatment as resulted in
    a. Placement in a psychiatric hospital, prison, or jail at least 2 times within the last 48 months, *or*

b. The individual's committing one or more acts, attempts, or threats of serious violent behavior within the last 48 months.

See MCL 330.1401(1)(d).

Procedures for Petition for AOT

Any individual over the age of 18 may file a petition with the court for an Order for AOT if the individual meets the above requirements. The petition must include:

- Facts supporting the need for AOT;
- Names and addresses of any witnesses to the facts; and,
- Names and addresses of any individuals/entities currently providing mental health treatment to the individual
- Names and addresses of the nearest relative, or guardian, if known, or if none, a friend of the individual, if known.

MCL 330.1433(1).

The rights of the alleged "person requiring treatment" regarding a petition for AOT remains the same as those for a hearing for involuntary hospitalization under the Michigan Mental Health Code, including the following:

- Court must give notice of petition and time and place of hearing to the individual or his or her representative, the petitioner, the spouse or guardian, or other relatives. MCL 330.1453.
- Within 4 days of receiving necessary documents, the court must give the individual a copy of petition and each clinical certificate, and notice of rights to a full court hearing, to be present at hearing, to be represented by legal counsel, to demand jury trial, and to have independent clinical evaluation. Counsel for the individual must be allowed to have sufficient time for investigation and prep, and must be permitted to present evidence. MCL 330.1454; 330.1455; 330.1458 to 1464.

Orders for AOT

If the court finds at the hearing that the individual meets the criteria of a person requiring AOT, and that outpatient mental health treatment is **not** scheduled to begin for the individual that includes case management services or assertive community treatment team services, the court must order the person to receive AOT through his/her local Community Mental Health Service Program (CMHSP). In addition, the order for AOT may include the following services:

- Medication
- Blood or urinanalysis tests to determine compliance with prescribed medications
- Individual/group therapy
- Day or partial day programs
- Educational and vocational training

- Supervised living
- Assertive community team treatment services
- Alcohol and/or substance abuse treatment
- Alcohol and/or substance abuse testing for an individual with a history of alcohol/substance abuse and testing is necessary to prevent a deterioration of his/her condition (which is subject to review every six months)
- Any other services prescribed to treat the individual's mental illness and either assist the individual in living and functioning in the community or prevent a relapse or deterioration that would reasonable likely lead to suicide or the need for hospitalization.

MCL 330.1433(3). See also MCL 330.1100a(6).

Duration of the AOT Order

The new provisions also limit the duration of Orders for AOT to 180 days, or 6 months. MCL 330.1472a(1)(d) If the CMHSP or mental health professional overseeing the AOT believes that the individual is still a "person requiring treatment," and that the individual is not likely to continue treatment voluntarily, a petition may be filed with the court at least 14 days before the expiration of the order for a second order for AOT. MCL 330.1473. If the court grants a second order for AOT, it cannot continue past one (1) year. MCL 330.1472a(2)(b).

If AOT is needed beyond the second order, a petition may be filed again under the same procedures for continuation of the second order, but it is not effective beyond one year. MCL 330.1472a(3)(b). Petitions may be filed prior to the end of each one year period until the individual no longer requires treatment. MCL 330.1472a(4).

Noncompliance with Order for AOT

The CMHSP or mental health provider must immediately notify court upon a determination that the person requiring treatment is not complying with the Order for AOT. The court then may require one or more of the following *without* a hearing:

- The individual must be taken to the preadmission screening unit established by the CMHSP for hospitalization;
- The individual must be hospitalized for a period of not more than 10 days; and/or
- Upon recommendation by the CMHSP, the individual is to be hospitalized for a period more than 10 days but no longer than the duration of the order for AOT or not longer than 90 days, whichever less.

Preferences regarding Mental Health Treatment

Fortunately, there are also provisions that attempt to minimize the use of this more intrusive intervention by the court regarding outpatient mental health treatment. In the new statutes, the court *must* consider any preferences and medication experiences reported by the individual or designative representative, whether or not an individual plan of service

exists, and any directions included in a durable power of attorney or advanced directive. MCL 330.1433(5)

If individual does not have a durable power of attorney or advanced directive in place, prior to expiration of the AOT Order, the CMHSP must determine whether the individual wishes to establish a durable power of attorney or advanced directive. If the individual wishes to, the CMHSP is required to direct the individual to the appropriate resources for assistance in developing an advanced directive. *Id.*

In addition, if AOT Order conflicts with previously existing advanced directives, durable powers of attorney, or individual plans of service, the AOT Order must be reviewed for adjustment by an independent psychiatrist not involved with developing AOT Order, and the court shall state its findings on the record, or in writing if the court takes matter under advisement, including the reason for conflict. MCL 330.1433(6)

b. Patient Advocate Designation for Mental Health Treatment

Previously, the statutes regarding a Patient Advocate Designation ("PAD") only permitted Patient Advocates to have authority to make decisions regarding medical care and end of life treatment. The new provisions have been passed and include the ability to designate a Patient Advocate for *mental health* treatment decisions when the individual is unable to do so, and requires the Patient Advocate to follow the individual's preferences regarding mental health care. See generally, MCL 700.5506 to 5512; 700.5515; 700.5520.

The rationale for the passage of such legislation for a PAD for mental health treatment, pushed by various advocacy groups, is to minimize the intrusive nature and court involvement of ordering AOT. In order to minimize the AOT provisions, not only is a PAD for mental health treatment now available, but as mentioned above, courts *must* consider the preferences of the individual regarding treatment if specified in a Patient Advocate Designation or any other writing, when considering court orders for AOT. In addition, the mental health provider must determine whether an individual participating in AOT wishes to execute a PAD for mental health treatment.

Triggering Event for the Patient Advocate to make Mental Health Treatment

The Patient Advocate may act on an individual's behalf to assist with mental health treatment decision-making when a physician **and** a mental health professional, determines the individual is unable to participate in mental health treatment decisions. In addition, the individual may designate specific physicians and/or mental health professionals to make this determination. MCL 700.5515(2).

Specific Grants of Authority for Mental Health Decisions

The law requires, however, that the Patient Advocate will *only* have the ability to assist with psychiatric hospitalizations of the individual and forced administration of medications if it is *clearly stated* by the individual in this Designation. MCL 700.5509(h). In addition, the Michigan Mental Health Code requires that the Patient Advocate may also only consent to electroconvulsive therapy (ECT) only if given explicit authority to do so. MCL 330.1717.

Waiver of the Right to Revoke for Mental Health Decision-Making

Typically, all individuals who execute PADs have the ability to revoke, or cancel, their PADs. However, the Michigan legislators were aware and attempted to accommodate for individuals who feel that any decisions they may make while they are unable to make their own mental health treatment decisions, will not necessarily be in their best interests. Thus, the new statutes provide the ability for the individual to waive their right to revoke their PAD, regarding only mental health treatment decisions. MCL 700.5515(1).

However, there are safeguards in place so that the waiver of revocation does not continue on indefinitely. If it is communicated at a later time that the individual wishes to revoke their PAD for mental health treatment while it has been determined that the individual is unable to participate in decisions regarding their own mental health treatment, and the individual is receiving mental health treatment at that time, that mental health treatment shall not continue for more than thirty (30) days. MCL 700.5515(1). After that time, one of the following may occur:

- No further treatment will be necessary;
- Assistant outpatient treatment is ordered by a court of competent jurisdiction; or,
- Involuntary psychiatric hospitalization is ordered by a court of competent jurisdiction under Michigan Mental Health Code.

Binding Effect on Mental Health Professionals

Under the new law, mental health and health care professionals must give follow the individual's wishes regarding mental health care. However, there are exceptions to this rule. The treating professionals are not bound to follow that desire if one or more of the following apply:

- In the opinion of the mental health professional, compliance is not consistent with generally accepted community practice standards of treatment;
- The treatment requested is not reasonably available;
- Compliance is not consistent with applicable law;
- Compliance is not consistent with court ordered treatment; or,
- In the opinion of the mental health professional, there is a psychiatric emergency endangering the life of the patient or another individual and compliance is not appropriate under the circumstances.

MCL 700.5511(4).

These exceptions are unlike the provisions related to health care decisions, where the health care professional *must* honor the preferences expressed by the individual in a PAD or other writing under all circumstances. Thus, these exceptions have raised some serious concerns by advocates due to the ease by which an individual's preferences may be ignored. Moreover, these exceptions have even raised questions regarding the legality of this provision under the Americans with Disabilities Act due to the differences in treatment of preferences regarding medical and mental health treatment, as a similar challenges have

been raised in another state whereby a similar statute was struck down by a federal court. See *Hargrave v. Vermont*, 340 F.3d 27 (2nd Cir. 2003). Whether the current Michigan statute will withstand scrutiny under the Americans with Disabilities Act remains to be seen.

Acceptance of Patient Advocate Designations

Lastly, the recent legislation revised the required statements that must be included in the *Acceptance of Patient Advocate* to be signed by the nominated Patient Advocates or Successor Patient Advocates upon the execution of the PAD. Previously, when the PAD only included decisions regarding medical care, the *Acceptance* forms required nine (9) limiting statements. Now, the *Acceptance* must include ten (10) limiting statements, one of which reflects the grant of powers to the Patient Advocate for mental health decisions. MCL 700.5507.

Furthermore, it is argued that the new statutes require the re-drafting and re-execution of the *Acceptance of the Patient Advocate* for previous *Patient Advocate Designations* even for only medical treatment decisions executed prior to these legislative changes.

The additional language added to the statutes relating to PADs clearly raise drafting challenges due to the different standards between medical and mental health treatment decisions. See **Appendix Two** for sample draft of a ***Patient Advocate Designation for Mental Health Treatment***. See **Appendix Three** for a sample draft of a ***Patient Advocate Designation for Medical & Mental Health Treatment***.

Clearly, there are benefits and concerns raised by these new changes. both in regards to Kevin's law and the PADs for mental health treatment. The practical effect of these new legislative changes, however, is unknown at this time. Nevertheless, it will be important for individuals, advocates and family members to stay apprised of these issues, so that the individual's rights and preferences regarding mental health treatment are honored should they become incapacitated and unable to make their own mental health decisions.

4. Trusts

Trusts are an additional way in which clients can plan for possible incapacity. Typically, a trust is created for an individual who is the Grantor or (Settlor), Trustee and Beneficiary. However, trust provisions typically include the nomination of a Successor Trustee, in the event of the individual's incapacity. The provision of a Successor Trustee ensures that the trust assets are managed for the benefit of the individual, or any other persons of his or her choosing, in the manner prescribed in the trust agreement, and that the trust assets are distributed in accordance with the individual's wishes upon the termination of the trust. When drafting trusts, language should also be included to permit the Successor Trustee(s) access information under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 to determine whether the current Trustee is capable of performing his/her duties.

An effective way to plan for incapacity, especially if an individual has been diagnosed with a progressive, de-habilitating disease (*e.g.*, Alzheimer's disease), by their family members is the establishment of a third party special needs trust. This is a particularly useful technique for ensuring that the individual's needs are met, and to preserve government benefits such as supplemental security income and/or Medicaid eligibility. A third party irrevocable special needs trust is established and funded with assets owned by

another individual for the benefit of the person with the disability, and will not affect the disabled individual's government benefits. It must be a pure *discretionary* trust, where its purpose is to supplement the individual's needs above and beyond what is provided through government benefits, and where the beneficiary has no right to demand distribution or access to those trust funds. If the person with a disability comes into their own funds, consider a self settled special needs trust. There are two kinds of self settled trusts, see Page 15, for more information on these.

II. When it is Too Late – Protecting the Individual After Incapacity Strikes

A. Probate Proceedings

1. Establishing Guardianships of Incapacitated Individuals

Michigan's Estate and Protected Individuals Code sets forth provisions to permit the appointment of a guardian to make decisions on behalf of individuals who become incapacitated and require assistance to manage their day-to-day affairs. MCL 700.5301-.5318. However, these provisions under EPIC only apply to petitions filed for "legally incapacitated individuals."[7]

A guardian may be appointed for a legally incapacitated individual (LII) if clear and convincing evidence is provided that the individual "is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, not including minority, to the extent of lacking sufficient understanding or capacity to make or communicate informed decisions." MCL 700.1105(a).

The establishment of a guardian for LII is very intrusive and therefore should be avoided unless it is in the best interest of the individual, as it involves the petition of a third party who sometimes a stranger, who requests a probate court judge that also may not familiar with the preferences of the individual, to decide that the individual no longer has ability to make decisions regarding his or her care. In addition, a guardian may be appointed who also may be a stranger, to make those decisions on his or her behalf, without knowing the preferences of that individual. Thus, it is important to be mindful of the following to ensure that the individual's decision-making rights are protected as much as possible:

- *Limited Guardian*. Either full or limited guardian may be established. If the court determines that the individual is completely without capacity to care for him or herself, then a full guardianship may be established. MCL 700.5306(4). However, the court also has the power to appoint a limited guardian it finds the individual lacks the capacity to do some, but not all tasks related his or her care. MCL 700.4306(3).

[7] Appointments of guardians for persons with developmental disabilities are governed however by Chapter 6 of the Michigan Mental Health Code. For more information regarding guardianships of persons with developmental disabilities, see ICLE's *Michigan Guardianship and Conservatorship Handbook* (2000), Chapter 8 " by Patricia E. Kefalas Dudek, Esq. and Kathleen Harris, Esq.

- *Assistant in decision-making is actually required*. There also must be evidence that appointment of a guardian "is necessary as a means for providing continuing care and supervision of the incapacitated individual." MCL 700.5306(1).

2. Establishing a Conservator

A good alternative to guardianship is the appointment of a conservator. A conservator is appointed for an individual to manage the estate of the individual. MCL 700.1103(h). In order for a conservator to be appointed, MCL 700.5401(3) requires clear and convincing evidence of the following:

- "The individual is unable to manage property and business affairs effectively for reasons such as mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, confinement, detention by a foreign power, or disappearance." **and**

- "The individual has property that will be wasted or dissipated unless proper management is provided, or money is needed for the individual's support, care, and welfare or for those entitled to the individual's support, and that protection is necessary to obtain or provide money.

Thus, even if the individual is determined be an individual in need of protection, the individual's legal capacity is not affected. MCL 700.5407. However, similar to the concerns related to appointment of a guardian due to the determinations by a third party and the appointment of a conservator to manage the individual entire estate, it is still a more intrusive method of assisting an individual. Thus, it is again important that there are no other less restrictive measure that can be taken to assist the individual, such as obtaining a protective order, or establishment of a representative payee, which are discussed below.

3. Protective Order

Under the Estates and Protected Individual's Code, a probate court may issue a protective order if the same facts are presented as for the appointment of a conservator as identified above, but finds that ongoing protection of the individual's estate is not required. MCL 700.5401(3). Thus, a protective order may be useful when an individual requires protection in a particular situation or single transaction. For example, one may be sought in order to approve the establishment of a special needs trust, or to purchase an annuity or engage in other Medicaid planning options. In order to obtain a protective order, there still needs to be clear and convincing evidence that the individual is in need of protection. MCL 700.5406(6). Because of the limited nature of the protective order, it is clearly a less restrictive alternative to conservatorship or guardianship.

B. Other Alternatives and Considerations

Other alternatives or strategies to assist an individual who did not adequately plan ahead for incapacity include the establishment of a representative payee, establishment of a special needs trust, issues related to incapacitated individuals who are business owners, and dealing with unsafe driving.

1. Representative Payee

The Social Security Administration (SSA) provides that any payments made on behalf of a beneficiary may be made to a representative payee rather than directly to the beneficiary if the beneficiary is unable to manage the money. 20. CFR 404.2001. Although the representative payee controls solely those funds paid out by the SSA, this designation still provides needed help to beneficiaries who are unable to manage the responsibilities associated with their Supplemental Security Income or Social Security Disability funds. Similar to a guardian, the representative payee acts, manages and spends the funds and must account to the SSA for the funds. 20 CFR 404.2035.

A representative payee is appointed only if the SSA determines that it would benefit the beneficiary because, he or she is unable to handle his or her payments due to legal incompetence, mental ability to manage the benefits, or physical inability to manage or direct management of the benefits. 20 CFR 404.2010. An attorney may request the appointment of a representative payee for a client by contacting the local SSA office on the client's behalf.

2. Self-Settled Special Needs Trusts

Furthermore, self settled special needs trusts are for individuals who are considered "disabled" as defined by the SSA, so that a trustee can manage the individual's assets for his or her benefit. Typically, SNTs consist of the individual's trust assets are established under 42 U.S.C. §1396p(d)(4)(A), or "Exception A" trusts, or under §1396p(d)(4)(C), or "Exception C" (more commonly referred to as "pooled accounts trusts." A trustee, who will act in the best interest of the individual with disabilities is instructed to manage those trust assets in order to:

- Preserve governmental benefits;
- Prevent waste or dissolution of the individual's assets, and
- Promote the quality of care and life of the beneficiary through goods and services not provided by government benefits. See attached OBRA-93 Trust Options for Persons with Disabilities and Permissible Distributions for an article about self-settled special needs trusts and a list of permissible distributions from both third party and self-settled special needs trusts.

3. Incapacity of Business Owners

Another somewhat common situation is when families request assistance for dealing with the possible incapacity of a loved one who owns a family business. This is of particular concern if the business employs a large number of employees, and when there is no one who clearly possesses the power to oversee the operations of the business while a possible petition for guardianship or conservatorship is pending. Often times, business owners have engaged in estate planning, and a dispute could be arising to determine a trigger or springing power to allow a Successor Trustee to take over management of the trust and the business interests if they are held in the trust.

In such circumstances, a *Petition for an Order to Seal Records* may be suitable in order to prevent irreparable injury, loss or damage to the business interests of the company

should it be discovered by other individuals, such as employees, or third parties conducting business that the individual's capacity is in question. This is particularly important to avoid abuse or exploitation of the individual's business interests. MCR 8.119(F) states in pertinent part:

> *(1)…a court may not enter an order that seals court records, in whole or in part, in any action or proceeding, unless*
>
> > *(a) a party has filed a written motion that identifies the specific interest to be protected,*
> >
> > *(b) the court has made a finding of good cause, in writing or on the record, which specifies the grounds for the order, and*
> >
> > *(c) there is no less restrictive means to adequately and effectively protect the specific interest asserted.*

For a sample *Petition for an Order to Seal Records*, see **Appendix Four**

4. Unsafe Driving

Lastly, frequently family members of individuals who are becoming gradually incapacitated may have to deal with other legal issues dealing with driving. Typically, reports of unsafe driving by an individual are made to the Secretary of State by law enforcement. However, the Secretary of State encourages reporting of unsafe drivers by other health care professionals, family members, friends or other individuals who may have concerns about the individual's driving abilities. Reports can be made to the Secretary of State by either:

1. Complete a "Request for Reexamination", form OC-88, attached as **Appendix Five**, available at the Secretary of State's office or online at http://www.michigan.gov/sos, or
2. Send a letter to the Secretary of State providing the following information:
   - Driver's full name, date of birth, current address or driver's license number (if you have this information);
   - Explanation of the reason for referral with specific facts supporting the concerns of unsafe driving by the individual; and,
   - The address, phone number and signature of the individual requesting the examination (you do not have to include this if you do not want to start family feud).

The information should then be mailed to:

Request for Driver Re-examination
Michigan Department of State
PO Box 30640
Lansing, Michigan 48909

After review and determination that re-examination is necessary, the department will contact the individual to attend the re-examination within 30 days of the request, and the individual making request will also be notified if you included this information.

Upon attending the re-examination, the individual may be requested to provide additional documentation regarding his/her physical condition. Failure to attend the re-examination will result in suspension of his/her driver's license until contact is made with the Department and attendance at the re-evaluation.[8]

[8] For more information, download the brochure entitled "Driving for Life: A Guide for Older Drivers and Their Families" at http://www.michigan.gov/documents/Older_Driver2_38985_7.pdf (last visited 04/18/05)

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