Advance Directive for Mental Health

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A Mental Health Advance Directive can help if you have a mental illness that sometimes effects your ability to make health care choices. You can also appoint a power of attorney for mental health and consent to specific treatments in advance that a general health care directive and power of attorney can't authorize. (Form and instructions)

Form attached:
Mental Health Advance Directive (NJP Planning 511)

Gather this information before you begin:

- Medications you take (name, dosage, pharmacy)
- Medications you're allergic to or had bad experiences with
- Contact info for your power of attorney (if any) and any alternates

What is a Mental Health Advance Directive?

It’s a form you use to say what you want to happen if your mental illness become so severe that you need help from others. It provides guidance for your health care power of attorney, friends, relatives, and health care

providers about what kinds of mental health care work best for you. It can let them know what kinds of care you need, including medications, treatments, and even who can visit you if you are in a hospital.

Your directive can include anything that might help others know how to give you the care you need when you experience severe symptoms from your mental illness, including the following examples:

- You can approve, refuse, or put limits on psychiatric **medications**.
- You can approve, refuse, or put limits on psychiatric **treatments**.
- You can approve **hospitalization** if your symptoms become severe.
- You can say who can and cannot **visit** you if you are in the hospital.
- You can name the **kinds of care you want medical staff to try** before they resort to more serious measures like restraints.

What if I have a Power of Attorney for Health Care?

You should attach a copy of your Power of Attorney form to your Mental Health Advance Directive.

> A general health care power of attorney **can't authorize** mental health hospitalization or electroconvulsive therapy (ECT). If you want your power of attorney to be able to consent to those things, you must appoint a power of attorney for mental health care. You can do that on your Mental Health Advance Directive form. You should appoint the same person as your agent for mental health care as for general health care to avoid confusion.

If you don't have a Power of Attorney for Health Care, you should fill that out too. You can fill it out separately or at the same time as your Mental Health Advance Directive on WA Forms Online.

> Think carefully about who you want as your power of attorney (agent). Choose someone that you trust to make decisions in line with your health care values, even if they would make different decisions for themself.

Can I still make my own decisions?

Under state law, you're capable of making your own decisions if you don't have a guardian and no judge has found you to be "incapacitated." You can read the state law about this, including the legal definition of capacity, at RCW 71.32.020 (http://app.leg.wa.gov/RCW/default.aspx?cite=71.32.020).

You can also change or cancel your Mental Health Advance Directive at any time. You can do this verbally or in writing. Make sure to tell your medical providers and anyone you gave power of attorney.

Does it need to be notarized?

It's best if you sign your directive in front of a notary.

If you can't find a notary, you can sign in front of 2 witnesses. Here's a list of people who **can't witness** your signature:

- Someone you've given power of attorney for health care to
- Your medical provider

- An owner or employee of any facility where you're a patient or where you live
- Anyone related to you
- Anyone who you're dating
- Anyone who could profit from you getting mental health treatment

What should I do after I sign this directive?

You should give it to any medical providers involved in your mental health treatment and any agent you've named in your directive and Power of Attorney.

You should also ask your local hospital if they'll put it on file for you.

Is a Mental Health Advance Directive legal?

Yes. A Mental Health Advance Directive is a legal advance directive. Medical providers are usually legally required to follow your advance directives. The best way to make sure your wishes will be honored is to talk with your medical team, your care facility, your caregivers, and your family members about your Mental Health Advance Directive.

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Mental Health Advance Directive

My name is _____. My date of birth is _____.

I am a person with decision-making capacity. I voluntarily sign this directive so my choices about my mental health care will be known when I cannot make decisions for myself. If any part of this directive is invalid, the rest should be honored. I revoke any mental health care directives I have signed in the past.

1. **Start date.** This directive is effective (*check one*):

   [ ] Now.

   [ ] Only if I can't make decisions for myself (if I'm incapacitated).

   [ ] When these circumstances, symptoms, or behaviors occur:

   _____

   _____

   _____

2. **End date.** I want this directive to (*check one*):

   [ ] Remain in effect until revoked.

   [ ] Automatically end _____ years from the date it was created.

3. **Revocation.** I can cancel (revoke) this directive (*check one*):

   [ ] **Only when I can make decisions for myself (when I have capacity).** I understand this means I can't cancel this directive unless I have capacity. It means I may receive the medical care and medication listed in this directive even if I object at the time.

   [ ] **Even if I cannot make decisions for myself (if I'm incapacitated).** I understand this means I can cancel this directive at any time. This means I may not get the medical care and medication listed in this directive when I am incapacitated.

4. **My care needs: What works for me.** I want my providers and my mental health care agent to know this information (*check all that apply*):

   [ ] I've been diagnosed with the following mental health and/or physical diagnoses:

   _____

   _____

   _____

   [ ] Here is the best treatment method for my illness (*give a general overview of what works best for you*):

   _____

   _____

   _____

   _____

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[ ] I take these medications or supplements:

_____

_____

[ ] I have a history of drug or alcohol abuse. Here are my preferences and treatment options around medication management related to drug or alcohol abuse:

_____

_____

My preferences and instructions

5. Medical providers. I want these medical providers to be involved in my mental health care decisions:

_____

_____

6. Medications (*check all that apply*)

[ ] I have allergies to or severe side effects from these medications:

_____

_____

[ ] I consent to these medications for mental health treatment:

_____

_____

[ ] I **do not** consent to these medications for mental health treatment:

_____

_____

[ ] I will take the medications excluded above if the following side effects can be eliminated by adjusting the dose or other means:

_____

_____

[ ] I will try any other medications for mental health treatment recommended by (*check one*)

[ ] any medical provider

[ ] these medical providers only:

_____

[ ] I **don't** want to try any other medications for mental health treatment.

[ ] Other medication preferences or instructions:

_____

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7. Alternative interventions

I want these interventions before psychiatric hospitalization is considered:

[ ] Call someone or have someone call me.

Name: _____ Phone/Text: _____

Email: _____

[ ] Stay overnight with someone.

Name: _____ Phone/Text: _____

Email: _____

[ ] Connect me with a peer counselor.

[ ] Connect me with a mental health care provider.

[ ] Go to a crisis triage center or emergency room.

Preferred location (if any): _____

[ ] Stay overnight at a crisis respite (temporary) bed.

[ ] See a medical provider for help with psychiatric medications.

[ ] Other: _____

8. Psychiatric Hospitalization

If you are worried you'll refuse to stay at a psychiatric hospital when your medical provider/s recommend it, you can consent to hospitalization in advance. If you don't consent, someone would have to get a court order for your involuntary commitment to a psychiatric hospital.

Important! By consenting to inpatient mental health treatment now, while you are well, you may get treatment sooner if you decompensate.

Check one (sign if consenting):

[ ] **I consent** to voluntary admission to inpatient mental health treatment for (*up to 14*) _____ days (*check one*):

[ ] With no limits.

[ ] With these limits (*check all that apply*):

[ ] My health care providers decide it is appropriate.

[ ] My mental health care agent (if I have one) decides it is appropriate.

[ ] Under these circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization):

_____

_____

▶ _____

My signature (*in front of a notary or witnesses*)

[ ] **I do not consent** to inpatient mental health treatment.

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9. Psychiatric hospital preferences and instructions

[ ] If I need hospitalization, I prefer these hospitals:

_____

[ ] If I need hospitalization, I **do not** consent to be admitted to these hospitals:

_____

[ ] **Alternative programs or facilities.** I prefer to get treatment in mental health programs or facilities that are alternatives to psychiatric hospitals, if possible.

[ ] No preference.

10. Seclusion, restraint, and emergency medications

If my behavior requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I've numbered them (*choose "1" for try this first, "2" for try this second, and so on*):

___ Seclusion

___ Seclusion and physical restraint (combined)

___ Medication by injection

___ Medication in pill or liquid form

If emergency medication is required, follow my preferences in section 6 (Medication) to the extent possible.

Interventions. I want the interventions below tried before use of seclusion, restraint or emergency medication is considered (*check all that apply*):

[ ] "Talk me down" one-on-one

[ ] More medication from my list of preferred medications above

[ ] Time out/privacy

[ ] Shift my attention to something else

[ ] Set firm limits on my behavior

[ ] Help me to discuss/vent feelings

[ ] Decrease stimulation

[ ] Offer to have neutral person settle dispute

[ ] Show of authority/force

[ ] Other: _____

_____

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11. Electroconvulsive Therapy (ECT)

Electroconvulsive therapy (ECT) is a medical treatment that involves sending an electric current through the brain to induce a brief seizure, or surge of electrical activity. The goal is to relieve severe symptoms of certain mental health conditions, such as severe depression or bipolar disorder that have not responded to other treatments.

You can consent to ECT in advance. If you don't consent, a medical provider would have to get a court order authorizing involuntary treatment.

Important! By consenting to ECT now, while you are well, you may get treatment sooner if you decompensate.

Check one (sign if consenting):

[ ] **I consent** to electroconvulsive therapy (*check one*):

[ ] With no limits.

[ ] With these limits (*check all that apply*):

[ ] My health care providers decide it is appropriate.

[ ] My mental health care agent (if I have one) decides it is appropriate.

[ ] Under these conditions only (*specify symptoms, behaviors, or circumstances that indicate the need for electroconvulsive therapy*):

_____

_____

_____

▶ _____

My signature (*in front of a notary or witnesses*)

[ ] **I do not consent** to electroconvulsive therapy.

12. Excluded visitors

If I've been hospitalized, these people may **not** visit me:

Name: _____

Name: _____

Name: _____

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13. Durable Power of Attorney for Mental Health Care (optional)

> ***Important!*** A general power of attorney for health care can't authorize mental health hospitalization or electroconvulsive therapy (ECT). If you want your power of attorney to be able to consent to those things, you must complete the power of attorney for mental health care section below. You should appoint the same person as your agent for mental health care as for general health care to avoid confusion.

[ ] I am **not** appointing a power of attorney **for mental health care**.

[ ] I am appointing a power of attorney **for mental health care** as follows. I revoke (cancel) any other power of attorney for mental health care documents I signed in the past.

a. Agent. I choose (*name*): _____ as my agent with full authority to manage my mental health care.

[ ] **Alternate.** If the agent named above is unable or unwilling to act, I choose (*name*): _____ as my agent with full authority to manage my mental health care.

[ ] **2nd Alternate.** If both the agent and alternate named above are unable or unwilling to act, I choose (*name*): _____ as my agent with full authority to manage my mental health care.

b. Spouse or partner.

[ ] Does not apply. I didn't name my spouse or partner as an agent or alternate.

[ ] One of the agents or alternates named above is my spouse or domestic partner. If we divorce or legally separate (*check one*):

[ ] Their authority to act as my agent is revoked.

[ ] They will continue to have authority to act as my agent.

c. My Rights. I keep the right to make mental health care decisions for myself if I am capable.

d. Durable. My agent can use this power of attorney to manage my affairs even if I become sick or injured and cannot make decisions for myself. My disability will not affect this power of attorney.

e. Revocation. I understand that I may revoke this power of attorney at any time by giving written notice of revocation to my agent.

f. Powers. My agent shall have full power and authority to make mental health treatment decisions on my behalf. This authority includes the right to make decisions consistent with any instructions and/or limitations in this directive. If my agent does not know my wishes, I authorize my agent to make the decision that my agent determines is in my best interest.

g. Nomination of Guardian. I nominate my agent as my guardian for consideration by the court if guardianship proceedings become necessary.

h. HIPAA Release. I authorize my healthcare providers to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to my agent.

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14. Other documents. I have attached the following other documents to this directive:

[ ] Durable Power of Attorney for Health Care (**not** mental health)

[ ] Durable Power of Attorney for Finances

[ ] Health Care Directive ("Living Will")

[ ] Other (*Examples: Crisis Plan, Wellness and Recovery Plan*):

_____

_____

15. Notifying others and caring for my personal affairs. If I'm admitted to a mental health facility, please follow my instructions on the attachment if possible. I understand the instructions on the attachment are not my medical providers' responsibility.

16. Acknowledgement. I understand the purpose and effect of this Mental Health Advance Directive. I understand consent to treatment or admission in this Mental Health Advance Directive constitutes my informed consent. I am signing of my own free will for the purposes stated in this document.

▶ _____ _____

My signature (*in front of a notary or witnesses*) Date

Notarization (preferred)

State of Washington
County of _____

This document was acknowledged before me on (date) _____

by (name) _____.

▶ _____

Signature of Notary

Notary Public for the State of Washington.

My commission expires _____.

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Statement of Witnesses (only if you cannot find a notary)

On (*date*): _____, (*name*): _____ signed this Advance Directive in my presence. This person is personally known to me or provided proof of identity. I believe they are able to make health care decisions, to understand this document, and to have signed it voluntarily. They do not appear to be acting under duress, undue influence, or fraud.

I am **not**:

- A person designated to make medical decisions for them
- A health care provider or professional directly involved in their care at the time the directive is made
- An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility where they are a patient or resident
- A person related by blood, marriage, or adoption to them
- In a dating relationship with them (see RCW 7.105.010)
- A minor or incapacitated person
- A person who would benefit financially if they undergo mental health treatment

Witness 1

▶ _____
Signature

Print Name: _____

Address: _____

_____

Phone: _____

Witness 2

▶ _____
Signature

Print Name: _____

Address: _____

_____

Phone: _____

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Mental Health Advance Directive
Attachment: Contact info, who to notify, personal affairs

My information

My name _____

My date of birth _____

My phone number _____

My email address _____

My mailing address _____

_____

My primary care medical provider

_____

Power of attorney

[ ] I have a **Durable Power of Attorney for Mental Health Care** that lets someone else (my "agent") make health care decisions for me if I'm not able.

My mental health care agent (if any)

Name _____

Relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

My alternate mental health care agent (if any)

Name _____

Relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

My 2nd alternate mental health care agent (if any)

Name _____

Relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

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Who to notify

If I'm admitted to a mental health facility, please notify these people as soon as possible:

Name: _____

Phone/Text: _____ Email: _____

Name: _____

Phone/Text: _____ Email: _____

Name: _____

Phone/Text: _____ Email: _____

Personal affairs

If I'm admitted to a mental health facility, these are my instructions about my personal affairs:

Dependents: _____

_____

_____

Pets: _____

_____

_____

Cars: _____

_____

_____

Household: _____

_____

_____

Other: _____

_____

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