ADVANCED DIRECTIVE
Mental Healthcare & Treatment

DEFINITIONS

Advanced Directive
An 'advance directive' is an arrangement made by competent persons regarding their healthcare treatment in the eventuality that they might become incompetent to make their own healthcare decisions.

Principal
A person making an advanced directive.

Agent
A person appointed by the principal (person making the advanced directive) as his/her agent to make healthcare decisions on his/her behalf in the event of incompetency.

Competency in healthcare
The ability of having sufficient knowledge, judgment and/or capacity to communicate ones needs, choices, will and preferences regards to one's own healthcare. Competency in mental healthcare may be temporarily diminished because of a mental health condition, resulting in limitations in making informed decisions about ones own health and wellbeing needs.

Supported Decision-Making
Supported Decision-Making allows individuals with mental health conditions to make choices about their own lives and mental healthcare with support from a team of people they choose.

Power of Attorney
A power of attorney is a legal document that allows someone else to act on your behalf. Powers of attorney can be helpful to choose a trusted person to act in your best interest when you cannot.

Crisis
In the context of this document, a crisis refers to particular difficulty with mental health problems, emotional distress and/or experience of a relapse (reappearance of debilitating symptoms of a mental health condition), that may have a negative impact on decision-making competency.

Template created by GLOBAL MENTAL HEALTH PEER NETWORK

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This **Advance Directive** is a document that allows the **Principal** *(person making this Advanced Directive)* to select an **Agent/s** *(someone else)* to make mental health care related decisions when he/she is not able to for him/herself.

A. POWER OF ATTORNEY: SUPPORTED DECISION-MAKING

This **Advance Directive** enables the **Principal** to choose his/her treatment options based on his/her will and preferences, in the event of decision-making limitations and/or lack of capacity to express his/her wishes. This **Advanced Directive** is not intended to give Power of Attorney on a permanent basis, but rather to support decision-making during a period of crisis (relapse or acute episode) and until such crisis has been stabilized.

B. WILL AND PREFERENCES

This **Advanced Directive** contains the will and preferences of the **Principal** pertaining to his/her choices and wishes for mental health care and treatment interventions in the event of a crisis.

C. SPECIFIC INSTRUCTIONS

This **Advanced Directive** contains specific instructions on how to approach and engage with the **Principal** based on his/her self-awareness and self-identified stressors that may exacerbate a crisis situation.

The **Principal** will review this **Advanced Directive** at least once a year and effect any changes should the current **Advanced Directive** no longer reflect the will and preferences of the **Principal**.

This **Advance Directive** is signed in the presence of two (2) witnesses.

The Principal hereby give permission for this Advanced Directive to be kept on record for safekeeping with the following individual/s listed below (eg psychiatrist, psychologist, peer support worker, agent, alternate agent, family member):

Person 1 (name):		**Relation:**	
Person 2 (name):		**Relation:**	
Person 3 (name):		**Relation:**	
Person 4 (name):		**Relation:**	

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I, (**Principal** name) _____, with personal details noted below, being of sound mind, willfully and voluntarily execute this mental health care **Advance Directive** to assure that, during periods of incapacity or incompetency resulting from a mental health condition, my choices regarding my mental health care will be carried out despite my inability to make informed decisions on my own behalf. In the event that a guardian or other decisionmaker is appointed by a court to make health care decisions for me, I intend this document to take precedence over all other means of ascertaining my intent while competent.

It is my desire that this **Advanced Directive** be considered a statement of my wishes and that it be accorded the greatest possible legal weight and respect. I understand that this **Advanced Directive** will become active and take effect upon my incapacity to make my own mental health decisions and shall continue in effect only during that incapacity.

The fact that I may have left blanks in this **Advance Directive** (i.e., not completed certain sections) should not affect its validity in any way. I intend that all completed sections be followed. If I have not expressed a choice, my **Agent** should make the decision that he/she determines is the decision I would make if I were competent to do so. If any part of this **Advance Directive** is invalid or ineffective under relevant law, this fact should not affect the validity or effectiveness of the other parts. It is my intention that each part of this **Advance Directive** stand alone. Even if some parts are invalid or ineffective, I desire that all other parts be followed. I intend this mental health care **Advance Directive** to take precedence over any and all living will documents and/or durable power of attorney for health care documents and/or other advance directives I have previously executed, to the extent that they are inconsistent with this document.

Personal Details: Principal

Full Name :

Surname :

Date Of Birth : _____ **ID Number** : _____

Home Address : _____

_____

Phone Number : _____

E-mail Address : _____

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A. POWER OF ATTORNEY: SUPPORTED DECISION-MAKING

I, the **Principal**, with above personal details, hereby select the below-named person as my **Agent** to support me in all matters relating to my mental health care and including, without limitation, to give or refuse consent to all medical treatments, hospitalizations, and all related mental health care. This power of attorney is effective at the point when I am no longer able to make informed decisions on my own or communicate my mental health care needs. My **Agent's** decisions under this power of attorney, during any period when I am unable to make and/or communicate my mental health care decisions, are binding on my heirs, devisees, and personal representatives.

Personal Details: Agent

Full Name :

Surname :

Home Address : _____

_____

Phone Number : _____

E-mail Address : _____

If my Agent is unable or unwilling to serve or make a decision in a timely manner, I select the below-named person to act as my alternate agent ("Alternate Agent").

Personal Details: Alternate Agent

Full Name :

Surname :

Home Address : _____

_____

Phone Number : _____

E-mail Address : _____

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B. WILL AND PREFERENCES

Having named an agent to act on my behalf, I do, however, wish to be able to discharge or change the person who is to be my agent if that agent is instrumental in the process of initiating or extending any period of psychiatric treatment against my will. My ability to revoke or change agents in this circumstance shall be in effect even while I am incompetent or incapacitated, if allowed by law. Even if I choose to discharge or replace my agent, all other provisions of this advance directive shall remain in effect and shall only be revokable or changeable by me at a time when I am considered competent and capable of making informed health care decisions.

1. My Choice of Treatment Facility and Preferences for Alternatives to Hospitalization If Emergency Care Is Deemed Medically Necessary for My Safety and Well-Being

In the event my mental health condition requires emergency care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.

I would prefer to receive emergency care at any of the following programs/ facilities:

In the event I am to be admitted to a hospital for emergency care, I would prefer to receive care at the following hospitals:

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I do not wish to be admitted to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:

Facility/hospital name:

Reason:

Facility/hospital name:

Reason:

Facility/hospital name:

Reason:

Facility/hospital name:

Reason:

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My Preferences Regarding Emergency Interventions

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made are as follows. I prefer these interventions in the following order:

Giving 1 to my first choice, 2 to my second, and so on.

Choice #		**Reason:**
	Seclusion	
Choice #		**Reason:**
	Physical restraints	
Choice #		**Reason:**
	Medication by injection	
Choice #		**Reason:**
	Medication by pill/liquid	
Choice #		**Reason:**
	Other, not listed above _____	

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My Preferences Regarding Medications

In the event that my attending physician decides to use medication for rapid tranquilization in response to an emergency situation after due consideration of my preferences for emergency treatments stated above, I expect the choice of medication to reflect any preferences I have expressed below. The preferences I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

If it is determined that I am not legally competent to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

Preferred medication/s:

Reason:

I specifically do not consent and I do not authorize my agent to consent to the administration of the following medications or their respective brand-name, trade-name or generic equivalents:

Medications **NOT** to prescribe:

Reason:

I consent to the medications agreed to as per my preferences and as agreed by my **Agent**, after consultation with my treating physician and any other individuals my **Agent** may think appropriate, with the reservations, if any, described above.

Any other preferences or reservations related to medication:

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I FURTHER CONSENT TO THE FOLLOWING RELATED TO MEDICATION	Yes	No
a) I consent to the medications deemed appropriate by my treating physician.	◯	◯
b) I am willing to take the medications excluded in above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.	◯	◯
c) I am concerned about the side effects of medications and do not consent or authorize my agent to consent to any medication that has any of the side effects as expressed above as reasons for not prescribing certain medications.	◯	◯

I FURTHER CONSENT TO THE FOLLOWING RELATED TO OTHER MEDICAL INTERVENTIONS:	Yes	No
a) I consent to the administration of electroconvulsive therapy.	◯	◯
b) I hereby consent to my participation in experimental drug studies or drug trials.	◯	◯
b) I authorize my agent to consent to my participation in experimental drug studies if my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, determines that the potential benefits to me outweigh the possible risks of my participation and that other, non-experimental interventions are not likely to provide effective treatment.	◯	◯

My Preferences About the Physicians Who Will Treat Me

My choice/s of physician/s and their contact details:

OR

*I do **not** wish to be treated by the following, for the reasons stated:*

OR

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2. Statement of My Preferences Regarding Notification of Others, Visitors, Custody of My Child(ren)/ Dependents, and Care for My Animals

Who Should Be Notified Immediately of My Admission to a Psychiatric Facility

If I am incompetent, I desire staff to notify the following individuals immediately that I have been admitted to a psychiatric facility:

Full Name :

Surname :

Home Address : _____

_____

Phone Number : _____

E-mail Address : _____

Relationship : _____

It is also my desire that this person be permitted to visit me: **Yes** ◯ **No** ◯

Full Name :

Surname :

Home Address : _____

_____

Phone Number : _____

E-mail Address : _____

Relationship : _____

It is also my desire that this person be permitted to visit me: **Yes** ◯ **No** ◯

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Who Should Be Prohibited from Visiting Me

I do **not** wish the following people to visit me while I am receiving care in a psychiatric facility:

Full Name :

Surname :

Relationship : _____

Phone calls from this person is permitted **Yes** ◯ **No** ◯

Full Name :

Surname :

Relationship : _____

Phone calls from this person is permitted **Yes** ◯ **No** ◯

Full Name :

Surname :

Relationship : _____

Phone calls from this person is permitted **Yes** ◯ **No** ◯

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My Preferences for Care and Temporary Custody of My Children/ Dependents

In the event that I am unable to care for my child(ren) or my dependents, I want the following person as my first choice to care for and have temporary custody of my child(ren) or dependents:

Full Name :

Surname :

Home Address : _____

_____

Phone Number : _____

E-mail Address : _____

Relationship : _____

In the event that the person named above is unable to care for and have temporary custody of my child(ren) or my dependents, I desire the following person to serve in that capacity.

Full Name :

Surname :

Home Address : _____

_____

Phone Number : _____

E-mail Address : _____

Relationship : _____

Specific instructions related to my children/ dependents:

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My Preferences for Care of My Animals

In the event that I am unable to care for my animals, I want the following person as my first choice to care of my animals:

Full Name :

Surname :

Home Address : _____

_____

Phone Number : _____

E-mail Address : _____

Relationship : _____

In the event that the person named above is unable to care for my animals, I desire the following person to serve in that capacity.

Full Name :

Surname :

Home Address : _____

_____

Phone Number : _____

E-mail Address : _____

Relationship : _____

Specific instructions related to my animals:

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C. SPECIFIC INSTRUCTIONS

In this Section I share pertinent information about myself, obtained through past experiences, self-awareness and self-identification of my stressors to allow for a better understanding of my preferences and on how to approach or engage with me in a situation of crisis, that will be least threatening or intimidating for me, and to avoid any personal trauma.

PLEASE NOTE THE FOLLOWING WHEN ENGAGING WITH ME ...		Yes	No
1)	It's ok to hug or touch me when I find myself in a crisis	◯	◯
2)	I feel comfortable and safe to be around people when I am in crisis	◯	◯
3)	I trust people close to me in times of crisis	◯	◯

The following are triggers that usually lead to a crisis or worsen a crisis

Other Instructions About Mental Health Care

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In this Section I share additional pertinent information about myself and my wishes in the events of a crisis or limitations on decision-making capacity.

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Statement of My Preferences Regarding Revocation or Termination of This Advance Directive

- My wish is that this mental health **Advanced Directive** may be revoked, suspended or terminated by me at any time, if state law so permits.

- My wish is that this mental health care directive may be revoked, suspended or terminated by me only at times that I have the capacity and competence to do so. I understand that I may be choosing to give up the right to change my mind at any time. I expressly give up this right to ensure compliance with my **Advance Directive**. My decision not to be able to change this **Advance Directive** while I am incompetent or incapacitated is made to ensure that my previous, carefully considered thoughts about how I want to be treated will remain in effect during the time I am incompetent or incapacitated.

- Notwithstanding the above, it is my wish that my **Agent** or other decisionmaker specifically ask me about my preferences before making a decision regarding mental health care, and take the preferences I express here into account when making such a decision, even while I am incompetent or incapacitated.

By signing here I indicate that I understand the purpose and effect of this document.

_____ **Principal** Signature, dated _____

The **Advanced Directive** above was signed and declared by the "Declarant," (Principal name) _____ _____, to be his/her mental health care **Advance Directive**, in our presence who, at his/her request, have signed names below as witness.

We declare that, at the time of the execution of this instrument, the **Principal**, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further declare that none of us is: 1) a physician; 2) the **Principal's** physician or an employee of the **Principal's** physician; 3) an employee or a patient of any residential health care facility in which the **Principal** is a patient; 4) designated as agent or alternate under this document; or 5) a beneficiary or creditor of the estate of the Declarant.

Dated at _____ (place), this _____ day of _____, 20___.

_____
Witness 1 (signature)

Name in print:_____
Date:_____

_____
Witness 2 (signature)

Name in print:_____
Date:_____