MENTAL HEALTH
ADVANCE DIRECTIVES
FORM

5.14

A Mental Health Advance Directive is a legal and medical document. Individuals are encouraged to use this tool as a way to inform and collaborate with their treatment providers. The goal is for the individual to receive the treatment most conducive to his or her mental health needs. Mental Health Advance Directives have been one of the more promising innovations in recent years to give individuals with a mental illness a greater voice in their treatment. Mental Health Advance Directives are now widely recognized across the country.

If an individual has concerns about being subject to involuntary psychiatric commitment or treatment at some time in the future, the individual can prepare a legal document in advance to express his or her choices about mental health treatment. This type of document is commonly referred to as a *mental health advance directive* or *psychiatric advance directive*. Through a mental health advance directive, an individual may also appoint an alternate decision-maker or agent, to make treatment decisions for the individual if the individual becomes unable to express choices.

There are many benefits to writing a mental health advance directive. It allows an individual to make decisions about treatment before the time it is actually needed. It allows the individual to make informed decisions when the individual's mental health is at its best and to make wishes clearly known. It is possible this document can shorten a hospital stay or even prevent the need for a guardian. It will improve communication between the individual and his/her doctor. It may prevent forced treatment.

Options for Completion

There are two parts to this form. Part I is for the appointment of an Agent (decision-maker). Part II is for the documentation of one's preferences and other provisions. Part I **or** Part II **or** both parts may be completed.

For each part chosen, there are selected items that must be completed. Others are optional and are marked accordingly.

Part I. MENTAL HEALTH ADVANCE DIRECTIVE:

Appointment of an Agent for Mental Health Care

_____
(legal name)

_____
(alternative name(s) used, if any)

A. Statement of Intent to Appoint an Agent

I, _____, being of sound mind, authorize an agent to make certain decisions on my behalf regarding my mental health treatment if I am not competent to do so. I intend that those decisions should be made in accordance with my expressed wishes as written in this document. If I have not expressed a choice in the document, I authorize my agent to make the decisions that he or she believes are the decisions I would make if I were competent to do so.

I hereby designate and appoint the following person as my agent to make mental health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

Legal name: _____

Alternative name used, if any: _____

Address: _____

Phone: Home _____ Cell _____ Other _____

I accept the designation as agent for _____

Agent's signature: _____ Date: _____

(OPTIONAL)

If the person above is unavailable or unable to serve as my agent, I hereby appoint and desire immediate notification of my alternate agent as follows:

Name: _____

Address: _____

Phone: Home _____ Cell _____ Other _____

I accept the designation as alternate agent for _____

Alternate agent's signature: _____ Date: _____

B. My Preference as to a Court-Appointed Guardian (OPTIONAL)

In the event a court decides to appoint a guardian for me, I desire this person to be appointed:

Name: _____ Relationship: _____

Address: _____

Phone: Home _____ Cell _____ Other _____

C. Advance Directive for Healthcare

☐ I have a separate advance directive for general healthcare. If you checked the box to indicate 'yes', check <u>one</u> of the two boxes below:

☐ The agent is the same as the agent I have appointed for mental health treatment.

☐ The agent is not the same person. Following is the contact information for my general healthcare agent:

Name: _____ Phone: _____

<u>NOTE</u>: The appointment of an agent for mental health treatment is in addition to the appointment of an agent for general healthcare. This appointment does not repeal the appointment of an agent for general healthcare.

*** **OR** ***

☐ I do not have a separate agent through an advance directive for general healthcare. If I later sign a general healthcare advance directive appointing an agent, that agent is in addition to the agent appointed through this document unless I specifically terminate this appointment.

D. Notary Public or Statement of Witnesses

This document **<u>must be notarized OR it must be witnessed</u>** by two qualified adult witnesses. If *notarized*, the person notarizing this document may be an employee of a health care or long-term care provider giving you care. If *witnesses* are used, at least one of the two witnesses to the execution of the document must not be a health care or long term care provider giving you direct care. None of the following may be used as a notary or witness: 1) a person you designate as your agent or alternate agent; 2) your spouse; 3) a person related to you by blood, marriage, or adoption; 4) a person entitled to inherit any part of your estate upon your death; or 5) a person who has, at the time of executing this document, any claim against your estate.

E. Date and Signature of Principal (person appointing the agent)

I, _____ *(your signature)*, sign this document, naming an agent for my mental health advance directive, on _____ *(date)* at _____ *(city)*, _____ *(state)*.

Option 1 – Notary Public

STATE OF NORTH DAKOTA

COUNTY OF _____

In my presence on _____ *(date)*, _____ *(principal)* acknowledged his/her signature on this document or acknowledged that he/she directed the person signing this document to sign on the principal's behalf.

_____ *(Notary Seal)*

Signature of Notary Public

Notary Public, _____ County
State of North Dakota

My commission expires on _____, 20____.

Option 2 – Two Witnesses

Witness #1:

In my presence on _____ *(date)*, _____ *(principal)* acknowledged his/her signature on this document or acknowledged that he/she directed the person signing this document to sign on the principal's behalf. I acknowledge that I am at least eighteen years of age. *If* I am a health care provider or an employee of a health care provider giving direct care to the principal, I must initial here: _____ I certify the above to be true and correct.

_____ _____
Signature of witness #1 *address*

Witness #2:

In my presence on _____ *(date)*, _____ *(principal)* acknowledged his/her signature on this document or acknowledged that he/she directed the person signing this document to sign on the principal's behalf. I acknowledge that I am at least eighteen years of age. *If* I am a health care provider or an employee of a health care provider giving direct care to the principal, I must initial here: _____ I certify the above to be true and correct.

_____ _____
Signature of witness #2 *address*

PART II. MENTAL HEALTH ADVANCE DIRECTIVE:

Statement of My Desires, Instructions, Special Provisions, and Limitations Regarding My Mental Health Treatment and Care

_____
(legal name)

_____
(alternative name(s) used, if any)

A. Agent's Access to Healthcare Records

☐ If I have an agent, I authorize my agent to have access to:

☐ all healthcare information, including drug and alcohol (addiction) records, needed to make healthcare decisions; **OR**

☐ my healthcare records with the following limitations: _____

_____

_____

*** **OR** ***

☐ I do not have an agent, or do not authorize my agent, to have access to my healthcare records.

B. Authority for Commitment

Your agent will have limited authority to commit you without a court order. An agent cannot consent to admission to a mental health facility or state institution for a period of more than forty-five (45) days without a mental health proceeding or other court order. Please check the following if this could apply to you.

☐ If necessary, I authorize my agent to commit me to a mental health facility or state institution.

*** **OR** ***

☐ I <u>DO NOT</u> authorize my agent to commit me to a mental health facility or state institution.

<u>NOTE</u>: NDCC § 23-06.5-03 (6) "Nothing in this chapter permits an agent to consent to admission to a mental health facility or state institution for a period of more than forty-five days without a mental health proceeding or other court order, or to psychosurgery, abortion, or sterilization, unless the procedure is first approved by court order."

C. Treatment Facility and Alternatives

If I do not require admission to a facility, the following options may be considered for me as an alternative:

Family member's home (list name): _____

Location: _____ Phone: _____

Friend's home (list name): _____

Location: _____ Phone: _____

In the event my mental health condition is serious enough to require 24-hour 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 designated as alternatives to psychiatric hospitalizations. I would prefer to receive any necessary 24-hour care at the following programs/facilities:

Program/Facility: _____ Location: _____

Program/Facility: _____ Location: _____

Program/Facility: _____ Location: _____

In the event I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals:

Hospital: _____ Location: _____

Hospital: _____ Location: _____

Hospital: _____ Location: _____

I do ***NOT*** wish to be admitted or committed to the following hospitals, programs, or facilities for psychiatric care, if an alternative is available, for the reasons I have listed:

Hospital/Program/Facility: _____

Reason: _____

Hospital/Program/Facility: _____

Reason: _____

Example: "irreconcilable differences with staff when I was there previously"

D. Emergency Interventions (OPTIONAL)

If, during an admission or commitment to a mental health treatment facility, it is determined that, despite substantial attempts using verbal de-escalation or other less intrusive techniques, I am engaging in behavior that requires an emergency intervention (such as seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency intervention should be used, in order of preference, are as follows (#1 is my first choice, and so on):

MY PREFERENCES AND REASONS

☐ seclusion _____

☐ physical restraint _____

☐ seclusion & physical restraint _____

☐ medication by injection _____

☐ medication in pill form _____

☐ liquid medication _____

☐ other _____

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 require the choice of medication to reflect any preferences I have expressed in this document. The preferences I express regarding medication in emergency situations does not constitute consent to the use of the medication for non-emergency treatment.

E. Professional/Provider Preferences if I am Hospitalized (OPTIONAL)

☐ Please consult with these physicians, professionals, and/or providers:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

F. Preferences for Medications for Psychiatric Treatment

If it is determined that I lack the capacity to consent, or if I refuse medications relating to my mental health treatment, my wishes are as follows (***initial only those that you agree to; write "NO" by those you do not agree to***):

a. ☐ I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with limitations, if any, described in (d) below.

b. ☐ I consent to & authorize my agent to consent to administration of:

Medication Name	Not to exceed the following dosage:	**OR**	In such dosages as determined by:
_____	_____		Dr._____
_____	_____		Dr._____
_____	_____		Dr._____
_____	_____		Dr._____

_____ *(initial if you agree)* If these medications prove ineffective, I authorize my agent to approve or disapprove medications, with the limitations in (d) below, after consultation with my treating physician and any other individuals my agent may think appropriate.

c. ☐ I consent to the medications deemed appropriate by:

Dr. _____ Phone: _____

Address: _____

d. ☐ I have had problems and/or risks associated with the following medications (or categories of medications) in the past and you may **NOT** treat me with them, their respective brand-name, trade-name or generic equivalents:

Medication Name	Associated problems/risks/allergies/intolerances
_____	_____
_____	_____
_____	_____
_____	_____

e. ☐ I am willing to take the medications excluded in (d) above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate or drastically reduce the likelihood of those side effects.

f. ☐ I am concerned about the side effects of medications and do *NOT* consent or authorize my agent to consent to any medication that has (check one of the following) ☐ *a high likelihood of* **OR** ☐ *any chance of* the side effects I have checked below (initial all that apply).

___ Tardive Dyskinesia ___ Neuroleptic Malignant Syndrome

___ Other: _____

___ Other: _____

g. ☐ I have the following other preferences regarding medications:

_____

_____

_____

G. Preferences Regarding Electroconvulsive Therapy (ECT) (OPTIONAL)

If it is determined that I am not legally capable of consenting to or refusing ECT (shock treatment), my wishes regarding ECT are as follows:
(***Initial 1 OR 2; if you initial 2, you must also initial 2a, 2b, or 2c***)

1. ___ I DO NOT consent to administration of ECT.
2. ___ I consent, and authorize my agent to consent, to the administration of ECT, but only (initial 2a or 2b or 2c):

   2a. ___ with the number of treatments that the attending psychiatrist deems appropriate;

OR

   2b. ___ with the number of treatments that Dr. _____ deems appropriate. Phone number and address of doctor: _____

   _____

OR

   2c. ____ for no more than the following number of treatments: ____

3. My other instructions and wishes regarding the administration of ECT:

_____

_____

_____

_____

_____

H. Consent for Experimental Studies or Drug Trials (OPTIONAL)

By my initials I agree to ***ONE*** of the following:

1. ___ I do *NOT* wish to participate in experimental drug studies or drug trials.
2. ___ I hereby consent to my participation in experimental drug studies or drug trials.
3. ___ 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.

I. Notification of Others (OPTIONAL)

If I am not competent, I desire staff to notify the following individuals immediately that I have been admitted to a facility, saying only that I have been admitted and where, but not providing further details. These may include my current physician, psychiatrist, psychologist, and other health care providers only if included in this list.

Name: _____Relationship: _____

Address: _____

Phone / Home: _____ Cell: _____Alternate #:_____

It is my desire that this person be permitted to visit me: Yes ☐ No ☐

Name: _____Relationship: _____

Address: _____

Phone / Home: _____ Cell: _____ Alternate #:_____

It is my desire that this person be permitted to visit me: Yes ☐ No ☐

Name: _____Relationship: _____

Address: _____

Phone / Home: _____ Cell: _____Alternate #:_____

It is my desire that this person be permitted to visit me: Yes ☐ No ☐

Name: _____Relationship: _____

Address: _____

Phone / Home: _____ Cell: _____Alternate #:_____

It is my desire that this person be permitted to visit me: Yes ☐ No ☐

Name: _____Relationship: _____

Address: _____

Phone / Home: _____ Cell: _____Alternate #:_____

It is my desire that this person be permitted to visit me: Yes ☐ No ☐

J. People Prohibited from Visiting Me (OPTIONAL)

I do NOT wish the following people to visit me while I am receiving care in a hospital or other facility:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

K. People I would like to Visit Me (OPTIONAL)

I would like the following people to visit me while I am receiving care in a hospital or other facility:

Name	Relationship
_____	_____
_____	_____
_____	_____

L. Preferences for Care & Temporary Custody of My Children (OPTIONAL)

In the event that I am unable to care for my child(ren), the following person is my <u>first choice</u> to care for and have temporary custody of my child(ren):

Name: _____ Relationship: _____

Address: _____

Phone: Home _____ Cell _____ Other _____

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

<u>My second choice</u>:

Name: _____ Relationship: _____

Address: _____

Phone: Home _____ Cell_____ Other _____

M. Preferences for Care of my Animals (OPTIONAL)

_____ has agreed to see that my pet(s), service animal, or therapeutic animal is properly cared for in case of an emergency. Please contact this person at _____ *(phone #)*. An alternate contact person is: _____ at _____ (phone #). The veterinarian is _____.

N. Other Instructions (OPTIONAL)

Other instructions that you would like followed can be described below. Examples may include dietary needs; cultural preferences; provision of a language interpreter, spiritual or religious needs (contacting my pastor, priest or religious leader, prayer, scripture reading); disability-related accommodations (quiet atmosphere, interpreter, etc.); medical needs; special therapies (music, art, etc.); treatment recommendations; and discharge planning recommendations.

_____

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O. Advance Directive for Healthcare

This mental health advance directive supplements any advance directive I already have for general healthcare. Any advance directive for general healthcare that I later sign supplements this mental health advance directive unless I specifically terminate this mental health advance directive.

P. Notary Public or Statement of Witnesses

This document must be notarized OR must be witnessed by two qualified adult witnesses. The person notarizing this document may be an employee of a health care or long-term care provider giving you care. If witnesses are used, at least one of the two witnesses to the execution of the document must not be a health care or long term care provider giving you direct care. None of the following may be used as a notary or witness: 1) a person you designate as your agent or alternate agent; 2) your spouse; 3) a person related to you by blood, marriage, or adoption; 4) a person entitled to inherit any part of your estate upon your death; or 5) a person who has, at the time of executing this document, any claim against your estate.

Q. Date and Signature of Principal (person completing form)

By signing here, I indicate that I understand the purpose and effect of this document. I, _____ *(your signature)*, sign this mental health advance directive on _____ *(date)* at _____ *(city)*, _____(*state)*.

(REQUIRED – OPTION 1 OR OPTION 2)

Option 1 – Notary Public

STATE OF NORTH DAKOTA

COUNTY OF _____

In my presence on _____ *(date)*, _____ *(principal)* acknowledged his/her signature on this document or acknowledged that he/she directed the person signing this document to sign on the principal's behalf.

_____ *(Notary Seal)*

Signature of Notary Public

Notary Public, _____ County
State of North Dakota

My commission expires on _____, 20____.

Option 2 – Two Witnesses

Witness #1:

In my presence on _____ *(date)*, _____ *(principal)* acknowledged his/her signature on this document or acknowledged that he/she directed the person signing this document to sign on the principal's behalf. I acknowledge that I am at least eighteen years of age. *If* I am a health care provider or an employee of a health care provider giving direct care to the principal, I must initial here: _____ I certify the above to be true and correct.

_____ _____

Signature of witness #1 *address*

Witness #2:

In my presence on _____ *(date)*, _____ *(principal)* acknowledged his/her signature on this document or acknowledged that he/she directed the person signing this document to sign on the principal's behalf. I acknowledge that I am at least eighteen years of age. *If* I am a health care provider or an employee of a health care provider giving direct care to the principal, I must initial here: _____ I certify the above to be true and correct.

_____ _____

Signature of witness #2 *address*

This form for Mental Health Advance Directives was published by the Protection & Advocacy Project and its Advisory Council for the Protection & Advocacy of Individuals with Mental Illness (PAIMI). Additional copies of this form, and the accompanying booklet, may be printed from P&A's website at www.ndpanda.org. If you need assistance or have questions, please feel free to contact P&A at 1-800-472-2670 (toll free) or (701) 328-3950 (Bismarck area). Use 711 for TDD relay. You can also e-mail panda@nd.gov.

RECORD OF ADVANCE DIRECTIVE - CONFIDENTIAL

Complete & keep this page along with a copy of your mental health advance directive.

Give a copy to your agent if you have appointed one.

My name: _____

My address: _____

My date of birth: _____

My agent's name: _____

My agent's address: _____

My agent's phone number: _____

My mental health advance directive is dated _____.
I have given copies to:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Insurance information:

_____

_____

_____

My social security number can be obtained by contacting:

Name: _____ Phone: _____

Name: _____ Phone: _____

Note other important information. Examples: who has a key to my home; who might check my mail or water plants; who might have authority with financial activity (bank account access, pay bills, safe deposit box access).

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