Psychiatric Advance Directive Instructions

Mental Health Association in New Jersey (800) 367-8850
Disability Rights New Jersey (800) 922-7233

A psychiatric advance directive is a document that allows you to make decisions about your mental health treatment in advance. Although there are some instances in which your plan may not be followed, writing a psychiatric advance directive is the best way to ensure that your wishes are known and carried out during a time in which you may be incapable of making decisions for yourself.

It helps to have one or more supporters assist you in writing this plan. Please remember to first discuss with your supporters how they can help you in a crisis and make sure that they are willing and able to be listed on this plan. It is a good idea to provide them with a copy.

Reminder: Complete your Psychiatric Advance Directive form when you are feeling well, not when you are in a mental health crisis.

You do not have to fill out all parts of the plan. If you wish to leave any sections of Parts 1-9 blank, put a line through it with your initials.

PAGE 1:
You can decide whether or not you want your Psychiatric Advance Directive followed only in the case that you lack capacity to make decisions about your care as determined by a medical professional; **Or** you can indicate that you'd still like the plan to be followed without that determination, and when you are experiencing the signs and symptoms that you list in Part 2 of the plan. Select one of these options.

Initial one of the statements regarding whether you would like to reserve the right to revoke your plan at any time, including when you are in a mental health crisis. If you know that you don't always make good decisions about your care when you are in a crisis, you may not want to be able to revoke your plan once it has been activated.

If you wish to name a mental health care representative please fill in the section that indicates who your primary mental health care representative will be. You may also choose an alternate in the case your primary is unavailable, unable or unwilling to serve as your representative. This should be a person with whom you trust to act consistently with your wishes that you've made for your mental health care. However, it is not necessary for you to designate a representative and you can name people who you would like to support you in other ways in Part 8.

PAGE 2:
Only if you have selected a mental health care representative do you need to complete page 2.

Item A- Select one of the two options for how you would like your representative(s) to make decisions about your care. This will apply if something is not specifically addressed in your plan, and your representative(s) is unaware of your wishes. The first option indicates that you want them to make decisions based on what they believe is the decision that you would make. The second option allows

the representative(s) to make decisions based on what they think is in your best interest, with consultation from your health care providers and other supporters that you've listed in your document.

Item B- Select one of the options to consent or not to consent to allow your representative(s) to admit you to an inpatient psychiatric hospital or a partial hospital day program and for how many days. This will mean that your representative can consent to your voluntary admission to a psychiatric facility if that is what is recommended by the treating medical professional(s). If you chose this option, you can write under what circumstances you would agree to be hospitalized. (For example, if you are experiencing auditory command hallucinations, refusing to eat, are experiencing a manic episode, have stopped taking medication, etc.)

PAGES 3-8:

Part 1: What you're like when you are well
Use words to describe yourself when you are feeling well. (for example, calm, cheerful, social, etc.) This will help others, especially those who don't know you, to identify how you feel and act when you are well.

Part 2: Symptoms
Describe what symptoms, signs and behaviors will indicate to others that you are in crisis and that they need to take responsibility for your care by following this plan. (for example, unable to sit still, uncontrollable pacing, not getting out of bed, refusing to eat, paranoid thoughts, neglecting hygiene, suicidal thoughts, using alcohol/drugs, etc.) Try to be as specific as possible.
Substance Use (Street Drugs/Alcohol/Prescription Medications): This section allows you to indicate possible substances that you've used in the past, before or during a crisis. It would also describe what you would be like if you were under the influence of that substance(s). You are not admitting to using any of the substances by completing this section.

Part 3: Supporters
In addition to any representatives that you've named, list the people (family, significant others, friends) whom you would like to be contacted along with anyone who you would not like to be involved in your treatment, if appropriate. You can also ask your supporters to do specific tasks for you. (for example, someone to pick up your mail and feed your pet, someone to pay the bills or inform your employer that you will be out of work, etc) If you are a caretaker of anyone in your home, a child, elderly person, etc., then list who they are and someone who can be contacted to take over or arrange their care for you.

Part 4: Medical Information
List all of your health care providers and indicate which ones, if any, that you'd like to have involved in your care during a mental health crisis. List your pharmacy and insurance information as well. Indicate any known medical conditions that you have. List all prescription and over the counter medications that you are currently taking, including any vitamins and herbal supplements. If you have a preference for receiving additional medication while in a crisis, indicate which ones you consent to along with those you do not consent to indicating the reason. You may list particular medications or a class of

medication. You may have come to this information based on past experiences. Additionally list any medications that you have a known allergy to.

Part 5: Help from my supporters and hospital staff:
List what your supporters and hospital staff can do to help you feel better and reduce symptoms when you are in a crisis. (For example, provide you with drawing materials, take you outside for walks, sit quietly with you, bring you relaxation music, magazines, etc) You can also indicate what actions or situations others should avoid that can make you feel worse, agitated, or upset. (For example, speaking loudly, being in a bright room, touching you, having more than one person speaking to you at once, trying to cheer you up, invalidating how you feel, etc.)

Part 6: Home Care/Community Care/Respite Care:
If you'd like to avoid hospitalization, you can develop an alternate plan that will keep you safe and provide you with support in a home or community setting. (For example, make a plan to stay with a family member for a certain period of time and have frequent visits with health care providers, stay in a respite supportive housing facility, be closely monitored at home through daily visits and phone calls from providers, friends, family etc.,)

Part 7: Hospitals and Treatment Facilities:
List hospitals and/or treatment centers from which you prefer to receive care as well as those you'd like to avoid. You may come to these decisions based on past experiences at these facilities or having a doctor who works at a particular hospital.

Part 8: Treatments and Therapies:
List any additional treatments that you would like to receive in a crisis situation. (for example, group therapy, creative arts activities, peer support/warmline, etc.) Additionally you can indicate treatments that you would like to avoid. (For example, seclusion, restraints, etc) Some people indicate their preferences regarding ECT (Electro Convulsive Therapy.) You can also list wellness techniques that help you recover from a crisis, such as getting extra sleep, journaling, walking, drawing, music, recovery literature, etc. and be permitted to have access to these things if possible.

Part 9: Inactivating the Plan:
List what signs indicate that you are feeling well enough to make your own decisions about your care and that your supporters no longer need to follow this plan. Be as specific as you can. (for example, you are eating 3 meals a day, you are no longer pacing, you have slept through the night for 2 nights in a row, you are socializing and talking to others, you are no longer hearing voices, you are no longer feeling hopeless or suicidal, etc.)

Sign and date your plan and have it signed by one or more witnesses. (see witness restrictions)

If you would like to register your advance directive with the NJ Division of Mental Health and Addiction Services (DMHAS), fill out the registration form provided and send it in with a copy of this plan. If you make changes to your plan, you need to have it resigned and dated and the new version sent to DMHAS. The plan with the most recent date will supersede all others.
Keep the original copy of your plan.