

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/warmlines, 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.

Registration

I hereby submit my mental health advance directive to the Division of Mental Health and Addiction Services in the New Jersey Department of Human Services to be registered.

I choose the following password that will permit access for me and anyone with whom I share it: _____ (If left blank, one will be assigned and provided to you.)

I further understand that a licensed health care provider who is providing me with mental health care may be able to access my directive if needed. No other person will be permitted to see the directive (except as required for administration of the registry) without my permission.

Signature _____ Print Name _____

Date _____

Please provide the following contact information for confirmation:

Street Address

Telephone Number

Email

Witness:

Signature _____ Print Name _____

Date _____

Send the original of this registration form and a copy of your entire mental health care advance directive to:

DMHAS - PAD Registry
PO Box 700
Trenton, NJ 08625-0700

You may also submit other documents to be registered that affect your legal ability to consent, such as a health care advance directive, durable power of attorney, temporary or limited guardianship orders, etc., which the registry will accept in its discretion.



Psychiatric Advance Directive (PAD)/Crisis Plan*
New Jersey Advance Directives for Mental Health Care Act
NJSA 26: 2H-108 et seq.



Name:

D.O.B.:

Phone:

Address:

I, _____, being a legal adult of sound mind, voluntarily make this declaration for mental health treatment.

Please select and initial one of the following statements:

_____ I want this declaration to be followed if I am incapable of making a decision or decisions about my care, as defined in New Jersey Statutes Annotated 26:2H-109.

_____ In the absence of a declaration of incapacity, I want this declaration to be followed as if I am incapable of making a decision or decisions about my care, as defined in New Jersey Statutes Annotated 26:2H-109, when signs and symptoms listed in PART 2 are evident.

Please select and initial one of the following statements:

_____ I can revoke this plan at any time as permitted by law.

_____ I do not wish to exercise my right to revoke this plan once it has been activated.

If it is determined that I am unable to make informed health care decisions for myself, I want the following person to act as my primary mental health care representative:

Name	Relationship to self	Phone 1
		Phone 2
Address		Email

I would like the following person to be my alternate mental health care representative:

Name	Relationship to self	Phone 1
		Phone 2
Address		Email

_____ I do not wish to appoint a mental health care representative.

*Adapted from the Wellness and Recovery Action Plan (WRAP®) Crisis Plan. Copyright by Mary Ellen Copeland
PO Box 301, W. Dummerston, VT 05357 Phone: (802) 254-2092 www.mentalhealthrecovery.com
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If you have designated someone as your mental health care representative, please answer sections A and B by initialing one of the statements. If you do not wish to appoint someone as your representative, do not complete this page.

A) Authority and Limitation of Authority of Mental Health Care Representative

I want my representative to make decisions about my treatment in the following way:
(Please select and initial one of the following statements.)

_____ Make decisions about my care based on what is in this document or, if not specifically expressed, as are otherwise known to my representative. If my wishes are unknown or are not specifically addressed in this document, make decisions based on what he/she believes would be the decision I would make.

_____ Make decisions about my care based on what is in this document or, if not specifically expressed, as are otherwise known to my representative. If my wishes are unknown or are not specifically addressed in this document, make decisions about my care that he/she thinks would be in my best interest, taking into consideration my preferences and consultation with providers and supporters as indicated in this document.

B) Please select and initial one of the following statements:

_____ I consent to giving my representative the authority to admit me to an inpatient or partial psychiatric hospitalization program for up to _____ days.

Optional: Describe the conditions under which you would agree to be hospitalized:

_____ I do not consent to give my representative the authority to admit me to an inpatient or partial psychiatric hospitalization program.

Name (Print):

The following are my wishes regarding my mental health care treatment in the event of a mental health crisis, including hospitalization:

Part 1. The following words describe me when I am feeling well:

Part 2. Symptoms

The following signs and symptoms will indicate that I am in a mental health crisis:

Substance Use (Street Drugs/Alcohol/Prescription Medications)

Without admitting to current use of substances, I offer the following information:

This is the substance(s) that I am or was most likely to use:

I feel and behave this way after taking this drug(s):

Part 3. Supporters

In the event that I am in a mental health crisis please contact the following person(s) in addition to any representatives named:

Name	Relationship to self	Phone 1	Phone 2
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I do not want the following people notified or involved in my care or treatment in any way:

Name	I do not want them involved because: (Optional)
_____	_____
_____	_____

If I am admitted to a hospital, I will need assistance with the following tasks:

I need (Name) _____ To (tasks) _____

I am a caretaker of the following person(s) at home:

The following person should be contacted to arrange substitute care:

Name	Phone 1	Phone 2
_____	_____	_____

Part 4. Medical Information

Primary Care Physician

Phone

Psychiatrist

Phone

Therapist

Phone

Case Manager

Phone

Pharmacy

Phone

Insurance Carrier

ID #

Phone

I would like the following health care providers to be notified and consulted about my care:

I have the following medical conditions:

Medications/Supplements/OTC (Over the Counter) preparations I am currently using:

Name

Dosage

Purpose

Name

Dosage

Purpose

Medications that have helped me in the past and that I consent to:

Name	Dosage	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications that I do not consent to or wish to avoid:

Name or type of medication	Reason Why
_____	_____
_____	_____
_____	_____
_____	_____

Medications that I am allergic to:

Name	Reaction
_____	_____
_____	_____

Part 5: Help from my supporters and hospital staff

Please do the following things that would help reduce my symptoms, make me more comfortable, and keep me safe:

Please AVOID doing the following things while I am in a crisis, as they may make me feel worse:

Part 6. Home care/Community care/Respite center

If possible, follow this care plan instead of hospitalization:

Part 7. Hospital or other Treatment Facilities

If I am being admitted to a hospital or treatment facility, I prefer the following facilities in order of preference:

1. Name Reason I prefer it

2. Name Reason I prefer it

AVOID using the following hospital or treatment facilities:

1. Name Reason to avoid it

2. Name Reason to avoid it

Part 8: Treatments and Therapies

The following treatments and therapies help me when I am in crisis:

Name	When to use this therapy
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_____	_____
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Treatments and Interventions that I do not consent to:

Name	Reason why
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_____	_____
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I would like to be permitted to use the following wellness techniques to help me in my recovery:

Part 9: Inactivating the Plan

The following signs, lack of symptoms or actions indicate that my supporters no longer need to use this plan and I am able to make decisions on my own behalf:

Signature of Declarant:

I, _____, being a legal adult of sound mind, voluntarily make this declaration for mental health treatment.

Signature _____

Date _____

Print Name _____

Any Mental Health Care Advance Directive plan signed with a more recent date takes precedence over this one.

_____ This plan has been registered with the state of New Jersey.

Witness:

I attest that the declarant signed this document (or asked another to sign this document on his or her behalf) in my presence, and that the declarant appears to be of sound mind and free of duress and undue influence. I am 18 years of age or older. I am not designated by this or any other document as the person's mental health care representative, nor as an alternate mental health care representative. At the time this document is being executed, I am not the responsible mental health care professional responsible, or directly involved with, the declarant's care.

Witnessed by _____

Date _____

Print Name _____

Second Witness:

(A second witness is required if the first witness is related to the declarant by blood, marriage or adoption, or is the declarant's domestic partner or otherwise shares the same home with the declarant; is entitled to any part of the declarant's estate by will or by operation of law at the time the advance directive is being executed; or is an operator, administrator, or employed of a rooming or boarding or residential health care facility in which the declarant resides.)

I attest that the declarant signed this document (or asked another to sign this document on his or her behalf) in my presence, and that the declarant appears to be of sound mind and free of duress and undue influence. I am 18 years of age or older. I am not designated by this or any other document as the person's mental health care representative, nor as an alternate mental health care representative. At the time this document is being executed, I am not the responsible mental health care professional responsible, or directly involved with, the declarant's care.

Witnessed by: _____

Date: _____

Print Name _____



**Mental Health
Association
in New Jersey, Inc.**

Name: _____

Date of Birth: _____

I have a Psychiatric Advance Directive registered with the NJ Division of Mental Health and Addiction Services. Please obtain a copy by calling Central Admissions (24/7) at 609-633-0861 or 609-633-1873.