Judge David L.
BAZELON CENTER
for Mental Health Law
www.bazelon.org

Psychiatric Advance Directives

If you are concerned that you may be subject to involuntary psychiatric commitment or treatment at some future time, you can prepare a legal document in advance to express your choices about treatment. The document is called an advance directive for mental health decisionmaking.

For a comprehensive set of resources on psychiatric advance directives, see The National Resource Center on Psychiatric Advance Directives, a joint project of the Bazelon Center with Duke University..

Forms for Creating a Psychiatric Advance Directive

- A. Directions for using the forms. (page 4)
- Part I. A statement of your intent in creating an advance directive for mental health care decisionmaking. This emphasizes your strong desire that providers respect your right to influence all decisions about your care. (pages 5-6)
- Part II. This form lets you name another person to make decisions for you if you are determined to be legally incompetent to make your own choices. Also, your instructions about the circumstances under which you can change your agent and who should be appointed your guardian if a court decides to name one. (pages 7-8)
- Part III. Your instructions about hospitalization and alternatives to hospitalization, medications, electroconvulsive therapy (ECT), emergency interventions (including seclusion, restraint and medication) and experimental studies or drug trials. (pages 9-13)
- Part IV. Your instructions about who should be notified immediately if you are admitted to a psychiatric facility, who should be prohibited from visiting you and who should have temporary custody of your child(ren). (pages 14-15)
- Part V. Here you may choose whether or not you will have the right to suspend or terminate your advance directive while you are incapacitated, if allowed by the law in your state. The section includes space for any other instructions about mental health care. (pages 16-17)
- Part VI. Signature page, on which you and two witnesses sign the advance directive, after you have filled in the blanks and made any changes you wish. There is also a form for use by a notary witnessing your signatures, if your state so requires. (pages 18-19)
- A form to record where your psychiatric advance directive can be found, You can copy this and keep it on your person. (page 20)

To browse the PAD, you will find a link at the end of each part to return to this page. You can print the whole document or only the pages shown above for each part. Parts I and VI are required for a valid PAD, while the others are optional.

Frequently Asked Questions

What are the advantages of a psychiatric advance directive?

If you expect to need mental health treatment in the future and believe that you might be found incompetent to make your decisions at that time:

- An advance directive empowers you to make your treatment preferences known.
- An advance directive will improve communication between you and your physician. It can prevent clashes with professionals over treatment and may prevent forced treatment.
- Having an advance directive may shorten your hospital stay.

Will my psychiatric advance directive be legally binding?

While advance directives for health care have been around a long time, their use for psychiatric care is a relatively new area of law. ***We do not yet know how courts will deal with them, especially when safety issues arise.*** State laws vary and it is possible that part or all of this document will not be effective in your state. However, many mental health consumers who are now using these documents find that an advance directive increases the likelihood that doctors, hospitals and judges honor their choices.

Please note that these template forms do not constitute legal advice. Before you assume that the advance directive you create using this form will be legally valid in your state, you should consult a lawyer.

Where can I get legal advice about advance directives in my state?

- The National Resource Center on Psychiatric Advance Directives (NRC-PAD) provides information about each state's requirements.
- Two articles on Advance Directives are available on the National Empowerment Center website: "Making Advance Directives Work for You," by Daniel Fisher, M.D., Ph.D. and "Advance Directives Are What You Make Them," by Xenia Williams.
- Your state Protection and Advocacy System (P&A) may also be able to tell you about your state's requirements or refer you to a lawyer who can. For the name and number of the system in your state, visit the website of the National Disability Rights Network or call NDRN at 202-408-9514. The Bazelon Center is not able to respond to individual inquiries.

Have any courts upheld the validity of psychiatric advance directives?

Permitting people who are not mentally ill to engage in advance planning through advance directive instruments on a wider basis than people with mental illnesses raises significant issues. A federal court in Vermont addressed such an issue in *Hargrave v. State of Vermont*, 340 F.3d 27 (2d Cir 2003).

Do I have to appoint an agent?

That depends on the law in your state. In some states, you may set up an advance directive without appointing a person to act for you. In most states, however, an advance directive for psychiatric care is only valid if you have named an agent. The Bazelon Center's study of advance directives suggests that these tools are much more likely to be honored when an agent has been appointed. We strongly urge consumers to name an agent whenever possible.

If you appoint an agent, it should be someone you trust. You can direct your agent to present the choices you have expressed in your advance directive. You can also authorize him or her to make other decisions about your care that are not in your directive. Or you can appoint an agent without giving any written instructions, but if you do this, you should clearly explain what your wishes are so he or she can advocate effectively on your behalf.

The template includes a provision (item 5 in Part II that your agent's decisions about mental health treatment would prevail even if a court appoints a guardian or conservator for you.

Does the document cover health care too?

No. The document you produce with these template forms will be an advance directive for mental health decisionmaking only; it will not cover decisions about other medical or surgical treatment. However,it is a good idea to have an advance directive for health care as well, stating your preferences about emergency medical treatment. Forms to create one are available from most hospitals and health agencies.

How do I get and use the templates?

We created the advance directive as six separate template forms rather than one, in part because it is easier to print or download as a series of smaller pages. The separation also makes the document more flexible. The only required sections are I, your statement of intent, and VI, the signature page—and in states that require an agent, II, the appointment of an agent. The other three templates are optional (though without at least one, you wouldn't have a directive), for you to express your preferences about hospitalization and treatment (III), about notification and visitors if you are admitted to a psychiatric facility (IV) and about the circumstances under which you can suspend the directive (V).

When we asked several mental health consumers to test the templates, it took them between 45 and 75 minutes to complete all six sections. Completing these forms is likely to take you under two hours.

Print this section for your future reference. Then go to the list of templates and print or download each one that you wish to use. If you prefer to edit the document directly, return to the web page and download the MSWord version.

Now proceed to the directions for using the forms.

Directions for Using the Advance Psychiatric Directive Forms

I. How to Fill Out the Forms

- Read each section carefully.
- Choose which parts you wish to use. Parts I and VI are required. If you aren't sure whether or not you want to use Part II, appointing an agent, find out if your state's law requires an agent for mental health decisionmaking. Your state protection and advocacy agency may be able to tell you. Parts III, IV and V are optional and cover the substance of your instructions.
- If you decide to appoint an agent, make sure he or she understands your wishes and is willing to take the responsibility. Your agent and alternate agent(s) should sign the form to show acceptance of the responsibility.
- Talk over your choices with your treating providers and your case manager.
- Fill in only the choices you want in sections III, IV and V. Your advance directive should be valid for whatever part(s) you fill in, as long as it's properly signed. You may cross out and/or write in words or sentences (or rewrite, if you are editing the document on a computer).
- To indicate which choices you want, put your initials in the blank at the beginning of a statement. If you do **not** want a statement to be true, leave the blank empty
- Add any special instructions in the spaces provided. Be sure you also put your initials in the blank at the beginning of that segment to make your choices valid. You can write additional instructions or comments on a separate sheet of paper, but be sure to write on the form that there are additional pages.
- Complete the checklist attached to Part I to show at a glance what your advance directive covers.
- Assemble the completed sections, renumber the pages and sign Part VI before two witnesses (see the list on the signature page of people who cannot be your witness). Some states may require a notary's signature as well; if you are not sure, it's best to have the document notarized.
- Have copies made and give them to your doctor(s), the individual(s) you have appointed to make mental health care decisions for you, your family and anyone else who might be involved in your care. Explain your choices to each of them
- Fill out the small form at the end to record your advance directive and carry it with you at all times.

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Advance Directive of (your name)_____ for Mental Health Care Decisionmaking

Part I. Statement of Intent

I, (your name) _____, being of sound mind, willfully and voluntarily execute this health care advance directive to assure that, during periods of incapacity or incompetency resulting from psychiatric or physical illness, 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.

By this document, I intend to create an advance directive for health care as authorized by state law, the U.S. Constitution and the Federal Patient Self-Determination Act of 1990 (P.L. 101-508) to indicate my wishes regarding mental health treatment. To the extent, if any, that this document is not valid under state law, it is my desire that it be considered a statement of my wishes and that it be accorded the greatest possible legal weight and respect. I understand that this 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.

My wishes expressed in this document should be honored whether or not my agent dies or withdraws or if I have no agent appointed at the time of the execution of this document. If I have not named an agent, these instructions shall be binding upon whomever may be appointed as my agent or other decisionmaker.

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 or 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.

Note to Provider: The next page is a checklist of the sections I have completed. Failure to follow the instructions in these sections (or the requests of my agent), even in emergency situations, may result in legal liability for professional misconduct and/or battery. I include this statement to express my strong desire for you to acknowledge and abide by my rights, under state and federal laws, to influence decisions about the care I will receive.

Instructions Included in My Directive

Put a checkmark in the left-hand column for each section you have completed.

____ Designation of my health care agent(s).

____ Authority granted to my agent.

____ My preference as to a court-appointed guardian.

____ My preferences about no termination in the event a guardian or other agent is appointed.

____ My choice of treatment facility and preferences for alternatives to hospitalization if 24-hour care is deemed medically necessary for my safety and well-being.

____ My preferences about the physicians who will treat me if I am hospitalized.

____ My preferences regarding medications for psychiatric treatment.

____ My preferences regarding electroconvulsive therapy (ECT or shock treatment).

____ My preferences regarding emergency interventions (seclusion, restraint, medications).

____ Consent for experimental studies or drug trials.

____ Who should be notified immediately of my admission to a psychiatric facility.

____ Who should be prohibited from visiting me.

____ My preferences for care and temporary custody of my children.

____ My preferences about revocation of my health care directive during a period of incapacity.

____ Other instructions about mental health care.

____ Duration of this mental health care directive.

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Part II. Appointment of Agent for Mental Health Care

Make sure you give your agent a copy of all sections of this document.

Statement of Intent to Appoint an Agent:
I, (your name)_____, being of sound mind, authorize a health care agent to make certain decisions on my behalf regarding my mental health treatment when I am incompetent to do so. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

1. Designation of Mental Health Care Agent
A. 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.

Note: Make sure to list this person in Part IV of your advance directive.

Name: _____

Address: _____

_____

Day Phone Number _____ Night Phone _____

B. Agent's Acceptance: I hereby accept the designation as agent for

(your name) _____

(your agent's signature)_____

Designation of Alternate Mental Health Care Agent
If the person named 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: _____

_____

Day Phone Number _____ Night Phone _____

Note: Make sure to list this person in Part IV of your advance directive.

Alternate Agent's Acceptance: I hereby accept the designation as alternate agent for

(your name)_____

(Your agent's signature)_____

The following paragraphs will apply when you appoint an agent.

2. Authority Granted to My Agent (*Initial if you agree with a statement; leave blank if you do not.*)

A. _____ If I become incapable of giving consent to mental health care treatment, I hereby grant to my agent full power and authority to make mental health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

B._____ 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.

3. When Spouse Is Agent and If There Has Been a Legal Separation, Annulment or Dissolution of the Marriage (*Initial if you agree with this statement; leave blank if you do not.*)

_____ I desire the person I have named as my agent, who is now my spouse, to remain as my agent even if we become legally separated or our marriage is dissolved.

4. My Preference as to a Court-Appointed Guardian
In the event a court decides to appoint a guardian who will make decisions regarding my mental health treatment, I desire the following person to be appointed:

Name:_____ Relationship:_____

Address: _____

City, State, Zip Code: _____

Day phone: _____ Evening Phone: _____

The appointment of a guardian of my estate or my person or any other decisionmaker shall not give the guardian or decisionmaker the power to revoke, suspend or terminate this directive or the powers of my agent, except as specifically required by law.

Make sure you give your agent a copy of all sections of this document.

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

In this part, you state how you wish to be treated (such as which hospital you wish to be taken to, which medications you prefer) if you become incapacitated or unable to express your own wishes. If you want a paragraph to apply, put your initials after the paragraph letter. If you do not want the paragraph to apply to you, leave the line blank.

1. My Choice of Treatment Facility and Preferences for Alternatives to Hospitalization If 24-Hour Care Is Deemed Medically Necessary for My Safety and Well-Being

A. _____ In the event my psychiatric 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 designed as alternatives to psychiatric hospitalizations.

A1. _____ I would prefer to receive 24-hour care at the following programs/facilities:

_____

_____

_____

_____

_____

_____

_____

_____

B._____ 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:

_____

_____

_____

_____

_____

_____

_____

_____

C. _____ I do ***not*** wish to be committed to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:

Facility's Name:_____

Reason: _____

Facility's Name: _____

Reason:_____

Facility's Name: _____

Reason:_____

2. 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:

Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well.

_____ seclusion

_____ physical restraints

_____ seclusion and physical restraint (combined)

_____ medication by injection

_____ medication in pill form

_____ liquid medication

_____ other:_____

_____

_____

Reasons for my preferences:

_____

_____

_____

_____

_____

_____

_____

Initial this paragraph if you agree; leave blank if you do not agree.

_____ 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 in this section and in Section 3. 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.

3. My Preferences About the Physicians Who Will Treat Me if I Am Hospitalized.
Put your initials after the letter and complete if you wish either or both paragraphs to apply.

A. _____My choice of treating physician is:

Dr. _____

Phone number _____

OR

Dr. _____

Phone number _____

OR

Dr. _____

Phone number _____

B. _____I do **not** wish to be treated by the following, for the reasons stated:

Dr. _____

Reason: _____

_____

_____

Dr. _____

Reason:_____

_____

_____

4. My Preferences Regarding Medications for Psychiatric Treatment

In this section, you may choose any of the paragraphs A-G that you wish to apply. ***Be sure to initial those you choose.***

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:

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 the reservations, if any, described in (D) below.

B._____ I consent to and authorize my agent to consent to the administration of:

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

C._____ I consent to the medications deemed appropriate by Dr._____,

whose address and phone number are: _____

_____

D. _____ 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:

Name of Drug	**Reason for Refusal**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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 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 any of the side effects I have checked below at a 1% or greater level of incidence (*check all that apply*).

_____ Tardive dyskinesia
_____ Loss of sensation
_____ Motor restlessness
_____ Seizures
_____ Muscle/skeletal rigidity
_____ Tremors
_____ Nausea/vomiting
_____ Neuroleptic Malignant Syndrome
_____ Other _____

G._____ I have the following other preferences about psychiatric medications:

_____

_____

_____

5. My Preferences Regarding Electroconvulsive Therapy (ECT or Shock Treatment)

If it is determined that I am not legally capable of consenting to or refusing electroconvulsive therapy, my wishes regarding electroconvulsive therapy are as follows:

Initial A or B; if you check B, you must also initial B1, B2 or B3:

A._____ I do ***not*** consent to administration of electroconvulsive therapy.

B._____ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy, but only:

B1. _____with the number of treatments that the attending psychiatrist deems appropriate;
OR
B2. _____ with the number of treatments that Dr. _____ deems appropriate.
Phone number and address of doctor:
_____
_____
_____
OR
B3. _____for no more than the following number of ECT treatments: _____

C. _____ Other instructions and wishes regarding the administration of electroconvulsive therapy:

_____

_____

_____

_____

_____

_____

6. Consent for Experimental Studies or Drug Trials

Initial one of the following paragraphs.

A. _____ I do ***not*** wish to participate in experimental drug studies or drug trials.

B. _____ I hereby consent to my participation in experimental drug studies or drug trials.

C. _____ 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.

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Part IV. Statement of My Preferences Regarding Notification of Others, Visitors, and Custody of My Child(ren)

1. 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:

Name:_____

Relationship: _____

Address: _____

_____

Phone (Day):_____

Phone (Eve.): _____

Mobile phone: _____

It is also my desire that this person be permitted to visit me: Yes_____ No _____

Name:_____

Relationship: _____

Address: _____

_____

Phone (Day):_____

Phone (Eve.): _____

Mobile phone: _____

It is also my desire that this person be permitted to visit me: Yes_____ No _____

2. 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:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

3. My Preferences for Care and Temporary Custody of My Children

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

Name: _____ Relationship: _____

Address: _____

City, State, Zip:_____

Phone: (Day) _____ (Eve.)_____ (Mobile) _____

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

My Second Choice	**My Third Choice**
Name:_____	Name:_____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
_____	_____
Phone (Day):_____	Phone (Day):_____
Phone (Eve.): _____	Phone (Eve.): _____
Mobile phone:_____	Mobile phone:_____

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Part V. Statement of My Preferences Regarding Revocation or Termination of This Advance Directive

Initial all paragraphs that you wish to apply to you.

1. Revocation of My Psychiatric Advance Directive

_____My wish is that this mental health directive may be revoked, suspended or terminated by me at any time, if state law so permits.

2. Revocation of My Psychiatric Advance Directive During a Period of Incapacity

_____ 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.

2A. _____ 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.

3. Other Instructions About Mental Health Care

(Use this space to add any other instructions that you wish to have followed. If you need to, add pages, numbering them as part of this section.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. Duration of Mental Health Care Directive

Initial A or B.

A._____It is my intention that this advance directive will remain in effect for an indefinite period of time. OR

B._____It is my intention that this advance directive will automatically expire two years from the date it was executed.

If my choice above is not valid under state law, then it is my intention that this advance directive remain in effect for as long as the law permits.

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Part VI. Signature Page

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

_____

Your Signature *Date*

The directive above was signed and declared by the "Declarant," (*your 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 Declarant, 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 Declarant's physician or an employee of the Declarant's physician; 3) an employee or a patient of any residential health care facility in which the Declarant 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 _____ (*county, state),*

this _____ day of _____, _20___.

Witness Signatures

Witness 1:	**Witness 2:**
_____	_____
Signature of Witness 1	*Signature of Witness 2*
_____	_____
Name of Witness 1 (printed)	*Name of Witness 2 (printed)*
_____	_____
Home address of Witness 1	*Home address of Witness 2*
_____	_____
City, State, Zip Code of Witness 1	*City, State, Zip Code of Witness 2*

Go to the notary form if your state requires it.

(for use by the notary):

State of_____, County of _____

Subscribed and sworn to or affirmed before me by the Declarant,

_____,

and (*names of witnesses*)

_____ and

_____,

witnesses, as the voluntary act and deed of the Declarant,

this _____ day of _____, _____.

My commission expires:

_____

_____
Notary Public

Seal:

Record of Psychiatric Advance Directive

Keep this form on you and give a copy to your agent, if you have appointed one.

_____	_____
My name	My health care agent's name
_____	_____
My address	My health care agent's address
_____	_____
_____	_____
My date of birth	My health care agent's telephone number(s)

I have given copies of this form to:

_____	_____
Name	Address or phone
_____	_____
Name	Address or phone
_____	_____
Name	Address or phone
_____	_____
Name	Address or phone
_____	_____
Name	Address or phone
_____	_____
Name	Address or phone
_____	_____
Name	Address or phone

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