



Mental health advance directive

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- ❖ You should use this *only* if you live in Washington State.
 - ❖ You can find all the fact sheets we link to here at [WashingtonLawHelp.org](https://www.washingtonlawhelp.org).
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What is a Mental Health Advance Directive?

This form lets you state what you want to happen if your mental health problems become so severe that you need help and treatments from others.

For example, if your mental health problems become severe enough that your judgment is impaired, or you are unable to say what you want, you can:

- let your decision makers and care providers know what medical care and mental health treatments have worked for you in the past and
- let them know what types of treatment or care you would like to get

What's included in a Mental Health Advance Directive form?

You can include anything that might be involved in your treatment in your mental health advance directive.

For example:

- consent for, or refusal of, particular medications or inpatient admission;
- who can visit you if you are in the hospital;
- anything else you want or don't want in your future care.

Does my Mental Health Advance Directive form say who will make decisions for me?

It can if you choose to name (appoint) a Mental Health agent in this form. Having an agent to advocate for you can really help make sure your mental health decisions are followed.

But if you also have a durable power of attorney form that lists a **different** agent for your general non-mental health decisions, things can get complicated.

If you use the form below to appoint a mental health agent, you should also fill out a [Durable Power of Attorney form](#) to choose a trusted friend or relative to help you with your other types of health care decisions. It's better if you can choose the **same agent** for both sets of decisions.

Our [Durable Power of Attorney Documents](#) has questions and answers, and forms and instructions for you to use.

Can I still make my own decisions?

Yes. You can still make your own health care decisions if you are capable. You can also change or cancel your directive at any time.

Does it need to be notarized?

You should sign your form in front of a notary.

If you cannot find a notary, you can sign in front of two "disinterested" witnesses.

What should I do after I sign it?

You should give it to your mental health and medical providers, your agent, and a trusted friend or relative.

You should also ask your local hospital if they will put it on file for you.

Are there other kinds of directives?

Yes. There are directives for care if you have a serious or terminal illness or dementia.

You can find these other directives at [WashingtonLawHelp.org](#).

Get Legal Help

- **Apply online** with [CLEAR*Online](https://www.nwjustice.org/apply-online) - [nwjustice.org/apply-online](https://www.nwjustice.org/apply-online)
- **Facing a legal issue in King County** (other than Eviction or Foreclosure)? Call 2-1-1 (or toll-free 1-877-211-9274) weekdays 8:00 am - 6:00 pm. They will refer you to a legal aid provider.
- **Facing a legal issue outside of King County** (other than Eviction or Foreclosure)? Call the CLEAR Hotline at 1-888-201-1014 weekdays between 9:15 am - 12:15 pm or apply online at [nwjustice.org/apply-online](https://www.nwjustice.org/apply-online).
- **Facing Eviction?** Call 1-855-657-8387.
- **Facing Foreclosure?** Call 1-800-606-4819.
- **Seniors (age 60 and over)** with a legal issue outside of King County can also call CLEAR*Sr at 1-888-387-7111.
- **Deaf, hard of hearing or speech impaired callers** can call any of these numbers using the relay service of your choice.

CLEAR and 2-1-1 will provide interpreters.

This publication provides general information concerning your rights and responsibilities. It is not intended as a substitute for specific legal advice.

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Mental Health Care Advance Directive of

[My Name]

I, _____, being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care.

1. My Care Needs - What Works for Me.

In order to assist in carrying out my directive I would like my providers and my agent to know the following information:

- I have been diagnosed with the following mental health and/or physical diagnoses:

- I take the following medications for my diagnoses:

- I am also on the following other medications:

- The best treatment method for my illness is the following (give general overview of what works best for you):

- I ____ have/____ do not have a history of substance abuse. My preferences and treatment options around medication management related to substance abuse are:

2. When this Directive is Effective.

I want this directive to become effective (*choose only one*):

- Immediately upon my signing of this directive.
- If I become incapacitated.
- When the following circumstances, symptoms, or behaviors occur:

3. Duration of this Directive.

I want this directive to (*choose only one*):

- Remain valid and in effect for an indefinite period of time.
- Automatically expire _____ years from the date it was created.

4. When I may Revoke this Directive.

I intend that I be able to revoke this directive (*choose only one*):

- Only when I have capacity. I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I may receive treatment that I specify in this directive, even if I object at the time.
- Even if I am incapacitated. I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated, I may not receive treatment that I specify in this directive, even if I want the treatment.

5. My Preferences and Instructions.

a. Physicians, Physician Assistants, and/or Advanced Registered Nurse Practitioners.

- I would like the physician(s), physician assistant(s), or advanced registered nurse practitioner(s) named below to be involved in my treatment decisions:

- I do not wish to be treated by:

b. Other Providers.

- I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

c. Medications for Psychiatric Treatment *(check all that apply):*

- I consent, and authorize my agent (if appointed) to consent, to the following medications:

- I do not consent, and I do not authorize my agent (if appointed) to consent, to the administration of the following medications:

- I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include:

and these side effects can be eliminated by dosage adjustment or other means.

- I am willing to try any other medication the hospital doctor, physician assistant, or advanced registered nurse practitioner recommends.

- I am willing to try any other medications my outpatient doctor, physician assistant, or advanced registered nurse practitioner recommends.

- I do not want to try any other medications.

- Medication Allergies. I have allergies to, or severe side effects from, the following:

- Other Medication Preferences or Instructions. I have the following other preferences or instructions about medications:

d. **Hospitalization and Alternatives** (check all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on):

- Alternative Programs/Facilities.** 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 prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.

- Alternative Interventions.** I would also like the interventions below to be tried before hospitalization is considered:

- Calling someone or having someone call me when needed.

Name: _____ Phone/Text: _____

Email: _____

- Staying overnight with someone

Name: _____ Phone/Text: _____

Email: _____

- Having a mental health service provider come to see me.

- Going to a crisis triage center or emergency room.

- Staying overnight at a crisis respite (temporary) bed.

- Seeing a service provider for help with psychiatric medications.

- Other:

- Authority to Consent to Inpatient Treatment:** I consent, and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for _____ days (not to exceed 14 days). (choose only one and sign):

- If deemed appropriate by my agent (if appointed) and treating physician, physician assistant, or advanced registered nurse practitioner.

(Signature)

- Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization):

(Signature)

- I do not consent, or authorize my agent (if appointed) to consent, to inpatient treatment.

(Signature)

Hospital Preferences and Instructions.

- If hospitalization is required, I prefer the following hospitals:

- I do not consent to be admitted to the following hospitals:

e. **Pre-emergency.** I would like the interventions below to be tried before use of seclusion or restraint is considered (*check all that apply*):

- "Talk me down" one-on-one
- More medication
- Time out/privacy
- Show of authority/force
- Shift my attention to something else
- Set firm limits on my behavior
- Help me to discuss/vent feelings

- Decrease stimulation
- Offer to have neutral person settle dispute
- Other: _____

f. **Seclusion, Restraint, and Emergency Medications.** If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen (*choose "1" for first choice, "2" for second choice, and so on*):

- Seclusion
- Seclusion and physical restraint (combined)
- Medication by injection
- Medication in pill or liquid form

In the event that my attending physician, physician assistant, or advanced registered nurse practitioner decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part 5(c) of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.

g. **Electroconvulsive Therapy** (ECT or Shock Therapy). My wishes regarding electroconvulsive therapy are (*sign one*):

- I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy.

(Signature)

- I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy.

(Signature)

- I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

(Signature)

- h. **Visitors.** If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

- Name: _____
- Name: _____
- Name: _____

I understand that persons not listed above may be permitted to visit me.

- i. **Additional Instructions.** Other instructions about my mental health care: (e.g. how to help me avoid hospitalization; how hospital or crisis staff can help me; how I usually react to hospitalization, etc.)

- j. **Refusal of Treatment.** I do not consent to any mental health treatment.

(Signature)

6. **Other Documents:** I have executed the following documents that include the power to make decisions regarding health care services for myself:

- Durable Power of Attorney. It's located

- Health Care Directive ("Living Will"). It's located _____

7. **Notification of Others and Care of Personal Affairs.** I understand the preferences and instructions in this part are NOT the responsibility of my treatment provider and that no treatment provider is required to act on them. (*Fill out this part only if you wish to provide nontreatment instructions.*)

- a. **Who Should Be Notified.** I desire my agent to notify the following individuals as soon as possible if I am admitted to a mental health facility:

Name: _____ Phone/Text: _____

Email: _____

Name: _____ Phone/Text: _____

Email: _____

Name: _____ Phone/Text: _____

Email: _____

- b. Preferences or Instructions about **Personal Affairs.** I have the following preferences or instructions about my personal affairs (e.g., care of dependents, pets, household) if I am admitted to a mental health treatment facility:

By signing here, I indicate that I understand the purpose and effect of this document and that I am giving my informed consent to the treatments and/or admission to which I have consented or authorized my agent to consent in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under chapter 7.70 RCW.

My Signature

Date

Notarization (preferred)

State of Washington

County of _____

I certify that I know or have satisfactory evidence that _____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

Date

Signature of Notary

NOTARY PUBLIC for the State of Washington.

My commission expires _____.

Statement of Witnesses (only if you cannot find a notary)

On (date) _____, the declarer of this document signed it in my presence. I believe the declarer is able to make health care decisions, to understand this document, and to have signed it voluntarily. I declare further that I am not:

- A person designated to make medical decisions on the declarer’s behalf;
- A health care provider or professional directly involved with the provision of care to the declarer at the time the directive is executed;
- An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the declarer is a patient or resident;
- A person who is related by blood, marriage, or adoption to the declarer, or with whom the declarer has a dating relationship as defined in RCW 7.105.010;
- A minor or incapacitated person;
- A person who would benefit financially if the principal undergoes mental health treatment

Witness 1

Witness 2

Signature

Signature

Print Name

Print Name

City/State

City/State