Psychiatric Advance Directives

A Workbook

This workbook will guide you through creating your own psychiatric advance directive, a legal tool that allows you to state your preferences for treatment in advance of a mental health crisis.

Acknowledgments

This workbook was created by Southern Regional AHEC as part of the Crisis Navigation Project, an initiative funded by The Duke Endowment to promote the use of psychiatric advance directives.

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You can find out more about the project at our website: http://www.crisisnavigationproject.org/

And you can find videos about psychiatric advance directives at our YouTube channel: https://www.youtube.com/channel/UC5RM6zz7gfnZSV9cOWC2FIw/videos

The information in this workbook follows the laws on psychiatric advance directives in North Carolina. For information on psychiatric advance directives in other states, you can find information at the National Resource Center on Psychiatric Advance Directives: https://www.nrc-pad.org/

Do you want more say in your mental health treatment?

If you are someone who is in psychiatric treatment, you might be interested in finding out how to have more say in your treatment, especially when you are in crisis. This guide will help you understand how a psychiatric advance directive (PAD) might be useful to you and will give you instructions on how to create one for yourself or to help a family member or friend create one.

One place to start is with your psychiatrist or other mental health treatment provider if you are interested in creating your own PAD. Ask if they know about PADs, and if they can help you create one. If they don't know about them, you can share this workbook with them so they can learn about them with you.

Peer support specialists and other community volunteers can help you with this process, too.

What is a psychiatric advance directive?

A psychiatric advance directive is a legal document that tells treatment providers your preferences for treatment in a crisis. It goes into effect if you are incapacitated – that means if you are in a state of mind where you cannot make rational decisions and communicate them. An example of being incapacitated would be if you were unconscious, or couldn't speak, or were experiencing significant confusion.

If you have a Wellness Recovery Action Plan, or WRAP Plan, or a Crisis Plan, there are some similarities with a PAD. A PAD is different because it is a legal document that preserves your right to make decisions about what happens to you in medical treatment settings. To make it legally valid, it must meet certain requirements and be signed in front of a notary public and two witnesses.

Treatment providers are required to follow your wishes stated in the PAD, unless those wishes include something they cannot do (like send you to a hospital in another state, or to a hospital that has no beds available), you ask for something that is not standard care, or it's an emergency and they need to preserve your safety or the safety of others.

Where did the idea for PADs come from?

Medical advance directives have been used for years for people who wanted more control over their medical care at times when they had a serious medical illness and knew they would not be

able to express their wishes on their own – like if someone was at the end of life. They were created as the result of the Patient Self-Determination Act of 1990, a federal law designed to give all adult patients more say in healthcare decisions.

The legal documents are also supported by North Carolina law. You can find information in the NC statutes about the Mental Health Advance Instruction and the Health Care Power of Attorney.

Are PADs always respected?

We hear from some people that their PAD was not followed during a crisis. They are not used often, and medical providers are just starting to learn more about them. By getting more people to create PADs, we hope to increase awareness of them and strengthen the voice of people who live with mental illness and to encourage more shared decision making with their treatment providers.

Do you have a trusted person who will help you in a crisis?

A PAD can include a health care power of attorney (HCPA). The HCPA is a legal document that lets you put someone in charge of communicating your wishes to medical providers if you are not able to. The person appointed by the HCPA is called your health care agent. That person can speak for you in a crisis. It's your choice to have a health care agent or not. Sometimes family members are in this role, and sometimes friends or another person you trust and who can help you in a crisis. The HCPA represents your preferences for your care, so it is important to choose someone who is comfortable doing that, and who can be available when needed.

Are there other benefits to having a PAD?

The process of creating a PAD helps you think through what you can do to prevent a crisis, what to do during a crisis, and how best to recover from a crisis. The conversations with your treatment providers and your family and friends can help you take control of your mental health and improve communication.

What do I need to think about before I create a PAD?

What kind of treatment is helpful to you? What medications work for you? What medications don't work for you? Is there a hospital that you prefer? Who should be contacted if you are in a mental health crisis? What practical matters in your life – like childcare, pet care, contacting your employer or paying your rent – need to be tended to if you are not able? You can include additional instructions tailored to what support you need in your PAD.

Preparing to create a psychiatric advance directive

Many people who create psychiatric advance directives start by reviewing previous experiences with mental health crises, and particularly with experiences with psychiatric hospitalizations.

We'll start with the advance instructions. This worksheet will help you think about the things that you might want to include in your form.

What you write in the form should be considered by treatment providers. It's important to remember that you are writing your **preferences**. While your preferences should be respected, there are some instances in which a treatment provider may not be able to respect your preferences, according to the law in North Carolina:

1.) If you request something that is not available.
2.) If you request something that is not considered "standard community treatment."
3.) If there are significant safety issues, you are under an involuntary commitment order or if there is a medical emergency.
4.) Even with these exceptions, the treating providers should review your preferences and follow them as closely as possible.

The Advance Instruction for Mental Health Treatment

Important things to remember:

These legal documents are important communication tools for you, your social support network and your treatment providers. They are most frequently useful during a crisis. To communicate well, keep things clear and simple.

The legal documents that make up a psychiatric advance directive communicate your treatment preferences during times that you lack decision-making capacity. A capacity determination is made by a physician or psychologist who examines you. Some examples of when a person might lack capacity include being unconscious, intoxicated, delirious, psychotic, or experiencing great difficulty with communication. This loss of capacity is usually temporary.

The following questions will guide you through the content needed to complete a psychiatric advance directive. You can then use the information to complete the legal forms which are included in the appendix.

Mental health history

Do you have a diagnosis? What is it? Have you been hospitalized before? Where? Do you have other medical conditions that treating providers should know about?

_____
_____
_____
_____
_____
_____

Consent for Treatment

The advance instruction allows you to consent for treatment in advance, in case you are not able to make health care decisions. Do you want to consent for treatment in advance? What kind of

treatment would you consent to? Under what circumstances? Or would you rather avoid hospitalization?

Medications:

What medications have been helpful to you, especially in a crisis? How were they helpful?

What medications were NOT helpful? Do you have known allergies to any medications? Or bad side effects? Describe why a medication was not helpful.

Facility preferences

Do you have a place you would prefer to be hospitalized, if you need to be in the hospital? Is there a place that you would NOT want to be hospitalized? (Keep in mind that bed availability, insurance, and other factors might influence where you can be admitted to the hospital).

Do you want to consent in advance to admission to a hospital or crisis facility?

Yes
No

A note on involuntary commitment: by law in North Carolina, a person can be held in custody and required to undergo a psychiatric evaluation if the person has a mental illness and has been determined to be a danger to self or other. For more information on the civil commitment process: https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/involuntary-commitments

People to contact when you are in mental health crisis

Outpatient treatment providers, including psychiatrists, therapists, primary care physician, and others involved in your care, including contact information:

_____
_____
_____
_____
_____
_____
_____

Family members and friends – who do you want involved in your care? (If you decide to use the Health Care Power of Attorney form to appoint a health care agent, the person designated will have the legal power to speak for you and to communicate your preferences. See more detail on that process later in this guide.)

_____
_____
_____
_____
_____
_____
_____

Are there specific people that you DO NOT want involved in your care?

Do you want to give permission in advance for certain people to visit you in the hospital, even if they are not directly involved in your care?

What do crisis responders need to know about you to help you if you are in mental health crisis?

What might cause you to go into mental health crisis? What would it look like if you were in mental health crisis?

What might help you when you are in mental health crisis? Are there things that would help you stay out of the hospital or a crisis facility?

What is it like for you when you are in the emergency room or the hospital? How do you react? For example, some people might be angry and upset, others might be quiet and withdrawn.

How do you want to be treated by staff? What kind of interaction would be helpful? What can staff do to avoid using coercive measures, like seclusion or restraint?

Do you have preferences for any specific kinds of medical treatment, including electroconvulsive treatment (ECT) or transcranial magnetic stimulation (TMS)? Would you consent to any of these special treatments in advance? Would you refuse them? Would you want the inpatient team to consult with your outpatient treatment providers on a plan of care?

Do you have other medical conditions that your treatment providers need to know about (diabetes, hypertension, etc.) including any medications you take for these conditions?

Other instructions

Do you have any other instructions you want to communicate to your support network on practical life issues like paying the rent or mortgage, taking care of children or pets, or contacting your employer?

How do you want your outpatient treatment providers involved in your care? Do you want inpatient staff to consult with them on treatment recommendations? (The information in your advance instruction will be shared with treatment providers involved in your care – this may be a team of providers, and it may be providers in different settings, for instance, the emergency room and the inpatient facility, residential treatment center, or crisis center.)

When you are ready to complete the legal form, remember that you will need to have the form signed in front of witnesses and a notary for it to be legally executed and valid. Copies of the legal forms are at the back of this guide. We recommend that you type them or print them neatly so providers can read them. You can also find electronic versions of the forms here: http://www.crisisnavigationproject.org/resources/

Health Care Power of Attorney

The Health Care Power of Attorney form allows you to designate a person to represent you during a period of incapacity. That person is called your health care agent and will have the legal right to speak for you when you are incapacitated. The person you select for this role should know your wishes for treatment, and be willing to communicate your wishes, not their own. When selecting someone to be in this role, be sure it's someone you trust and talk with

them first to be sure that they are willing and able to serve in the role of health care agent. It would be best if it is a person who lives close to you, so that they come to the emergency room, crisis facility, or hospital to speak with your treatment providers. They only speak for you when you are found to lack capacity by a physician or psychologist. A health care agent can also be your advocate. You can name more than one person as a health care agent in order of priority. Having a health care agent is your choice and you are not required to have one.

The legal form for a health care power of attorney is used across health care settings, not just in mental health settings. The form in North Carolina also includes information about end of life care planning. You can learn more about end of life care planning here: NC Partnership for Compassionate Care.

You can decide if your health care agent should have broad decision making power – making any decision for you – or more limited decision-making authority.

Who do you want to be your health care agent? You can select more than one person for this role. The order in which they are listed determines who will be contacted first. What is the person's relationship to you? (The person you select should not be one of your treatment providers.)

_____
_____
_____
_____
_____

What decisions do you want your agent to make for you? Do you want the agent to refer to your advance instruction for mental health treatment to guide decisions?

_____
_____
_____
_____
_____

The Health Care Power of Attorney form includes information about medical treatment options if you have a serious medical illness, or are at the end of life. Are there treatments that you

would want, or not want, including cardiopulmonary resuscitation (CPR), mechanical ventilation, artificial nutrition or artificial hydration?

If you were very ill and at the end of life, would you want to stop treatment and receive comfort care? Would you want your pain to be treated?

Where would you want to be if you were at the end of your life? Your home? A hospital? A nursing home? Who would you want to be with you?

What arrangements would you want to make after your death? Do you want a funeral or a memorial service? Who should be contacted in your faith community? What do you want to happen to your body (burial, cremation, autopsy, donation of organs, etc.)

Next Steps

After you've completed this workbook, the next step is to complete the legal forms. There are samples of the forms for North Carolina in the appendix of this workbook. When you complete them, make sure they are legible – type them if you can. To make them legal documents, they must signed in front of a notary public and two witnesses. You can find a notary public at banks, some office supply stores, legal offices, and medical facilities.

The witnesses should be people who know you, if possible. They cannot be family members or people who are involved in your treatment or who are employed by a facility where you receive care. These restrictions are designed to protect you from being exploited. A bank may be able to provide witnesses for you, and a notary, or an office supply store for a fee.

Once your document is signed and legally executed, make copies. Keep the original. Give a copy to any medical facility where you might go for mental health treatment and ask them to include it in your medical record. Give copies to your health care agent(s), if you chose to have one, and to other important people in your support network.

We've included a sample of a wallet card in the appendix that you can use to carry with you with summary information from your psychiatric advance directive.

You can revoke your psychiatric advance directive at any time. To revoke it, you will need to notify places that have a copy either verbally or in writing. To make a change to your documents, you will need to create new copies and go through the signing, witnessing, and notarizing process again.

The NC Secretary of State has an online secure repository for advance care planning documents. If you want a copy of your documents stored here, you will need to mail a copy with a fee. They will scan and upload the documents to their system and send you logon and password information on a wallet card. This option allows you to access your documents from anywhere you can access the internet.
https://www.sosnc.gov/forms/by_title/_advance_healthcare_directives This site is a good place to get up-to-date information on the NC laws governing all healthcare advance directives.

Electronic health records of major health systems often allow you to upload documents through their patient portals. You can check to see if this is an option available to you.

Finally, make sure to communicate your preferences to people in your support network so that they can best support you in times of mental health or medical crisis.

Glossary of Terms Related to Psychiatric Advance Directives

Advance Directive: A legal document that states a person's preferences for treatment in advance. It is activated if the person is unable to speak for themselves at times of incapacity, or unable to make decisions secondary to a medical or mental state. An advance directive for end of life care is also called a living will. Each state has their own laws that govern advance directives and their use. They are supported at the federal level by the Patient Self-Determination Act of 1990.

Advance instruction: A legal document that may be part of an advance directive. It includes specific instructions about preferences for medical treatment, including consent for treatment and admission to a hospital in advance of a crisis.

Capacity: The ability to make informed decisions about your own medical care. You must be able to take in information, understand your choices and communicate your decisions. If you are unable to make decisions for yourself, doctors can turn to other people to make decisions for you. Loss of capacity is usually temporary, until you are well enough to make decisions again. It is important to note that state laws on capacity may differ. Advance directives allow a person to state what they want to happen with medical treatment and who they want to make decisions for them in advance of a period of incapacity (examples of states of mind that affect capacity: consciousness, delirium, dementia, cognitive impairment, psychosis, intoxication, and confusion). Capacity is determined by a treating physician or psychologist upon in-person examination. The treating physician or psychologist must exam the person and make a determination about capacity. If the person lacks capacity, the physician must document that in the chart and then can use the advance instruction to learn the person's preferences for care, and who to contact.

Health Care Agent: A person who has been given legal power to make decisions on behalf of the person through the legal instrument called a health care power of attorney. The person chooses who to designate as their health care agent. They can designate more than one person, in order of preference in case the first person designated is not available when needed. A health care agent represents what the person wants in their treatment, and should be willing and able to serve in the role as the person's representative and advocate.

Health Care Power of Attorney: A legal instrument that allows a person to name individuals who can make decisions for them when they lack decision-making capacity. The person

designated through this instrument is called a health care agent or a surrogate decision maker. The health care agent represents the person's wishes, and those wishes should be communicated in advance. The wishes can also be spelled out in an advance instruction. The power of attorney can usually grant either very broad or narrowly defined powers for the health care agent, depending on the preferences of the person.

Incapacity: The state of lacking decision-making capacity. This is usually a temporary state that is determined by a physician or a psychologist upon examination of a patient. A person may experience incapacity if they are unconscious, delirious, intoxicated, psychotic, manic or catatonic, among other states.

Incompetence: A legal determination based on whether a person has a long-standing lack of capacity or lack of ability to manage their own affairs. Incompetence is decided in a court hearing based on medical evidence. If a person is found to be incompetent, then a judge will appoint a legal guardian to make decisions for the person. There are different types of guardianship, including guardian of the person and guardian of the estate. To reverse the legal finding of incompetence, a person must petition the court and provide medical evidence of competence.

Informed Consent: The process of making decisions about medical treatment based on the provision of good information about risks and benefits of the treatment offered.

Involuntary commitment: A civil process through which a person is taken into custody and evaluated at a psychiatric facility. If the person is found to meet criteria for inpatient or outpatient commitment – usually having a mental illness and exhibiting dangerousness to self or other—the person may then be admitted to an inpatient facility against their will, or required to participate in outpatient treatment. The process of developing a psychiatric advance directive may lessen the need for involuntary commitment. If a person is under involuntary commitment, their psychiatric advance directive can be disregarded, but it still may include valuable information for the crisis and inpatient teams.

Guardian: A person appointed by the court to make decisions for a person who has been legally adjudicated incompetent.

Living Will: A legal document that gives advance instructions about how a person wants to be treated if seriously ill, especially around end of life care. It may include information about resuscitation, artificial nutrition, and organ donation after death. A living will takes effect when the person is unable to speak for him/herself.

Protection and Advocacy (P&A) Agency: A state agency charged with protecting the rights and advocating for people with mental illness, intellectual disabilities and other disabilities, especially when they are in hospitals or other institutions. In North Carolina, Disability Rights NC serves as the Protection and Advocacy Agency.

Psychiatric Advance Directive: A form of advance directive that addresses preferences for treatment in advance of a mental health crisis. The psychiatric advance directive (PAD) can include an advance instruction specific to mental health treatment, including consent for treatment and admission to a hospital. It can also include a health care power of attorney to appoint a health care agent to make decisions if the person is unable to make those decisions secondary to incapacity.

Revocable: The ability to cancel your advance directive. Generally, a person can revoke their advance directive when they have legal capacity. To change the content of the advance directive, the person must first revoke the existing advance directive and then create a new one.

Repository: A central location where documents can be kept safe and made available to people with permission to access them, as in an online repository.

Self-binding, or the Ulysses clause: A term used to describe a situation in which a person decides to bind themselves to previous decisions about treatment in a future crisis, rather than making a decision in their present state of mind. Some people may never be comfortable giving up this autonomy, and may not be willing to create a psychiatric advance directive.

Shared decision-making: The process in which patients and physicians and other treatment providers collaborate on health care decision making based on best information and options available, and the patient's values and preferences. It is a corner-stone of patient-centered and person-centered care.

Supported decision-making: The process in which persons with disabilities are able to make decisions about their healthcare and lives with the support of a team of individuals. It is an alternative to guardianship, and may be useful for people who lack full decision making capacity on a more persistent basis, but who are still able to express their preferences for care and services.

Surrogate decision maker: Another term for a health care agent or a guardian—a person who makes decisions for a person who lacks capacity or is unable to communicate decisions. If the

person has no legally appointed person in this role, medical providers will usually go to next of kin if available.

Appendix

Advance Instruction for Mental Health Treatment

Health Care Power of Attorney

Wallet Card

STATE OF NORTH CAROLINA

ADVANCE INSTRUCTION FOR
MENTAL HEALTH TREATMENT

COUNTY OF _____

(NOTICE TO PERSON MAKING AN INSTRUCTION FOR MENTAL HEALTH TREATMENT)

This is an important legal document. It creates an instruction for mental health treatment. You should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State: http://www.sosnc.gov.

Before signing this document you should know these important facts:
This document allows you to make decisions in advance about certain types of mental health treatment. The instructions you include in this declaration will be followed if a physician or eligible psychologist determines that you are incapable of making and communicating treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held in accordance with civil commitment law. Under the Health Care Power of Attorney you may also appoint a person as your health care agent to make treatment decisions for you if you become incapable. You have the right to revoke this document at any time you have not been determined to be incapable. YOU MAY NOT REVOKE THIS ADVANCE INSTRUCTION WHEN YOU ARE FOUND INCAPABLE BY A PHYSICIAN OR OTHER AUTHORIZED MENTAL HEALTH TREATMENT PROVIDER. A revocation is effective when it is communicated to your attending physician or other provider. The physician or other provider shall note the revocation in your medical record. To be valid, this advance instruction must be signed by two qualified witnesses, personally known to you, who are present when you sign or acknowledge your signature. It must also be acknowledged before a notary public.

NOTICE TO PHYSICIAN OR OTHER MENTAL HEALTH TREATMENT PROVIDER

Under North Carolina law, a person may use this advance instruction to provide consent for future mental health treatment if the person later becomes incapable of making those decisions.

Under the Health Care Power of Attorney the person may also appoint a health care agent to make mental health treatment decisions for the person when incapable. A person is "incapable" when in the opinion of a physician or eligible psychologist the person currently lacks sufficient understanding or capacity to make and communicate mental health treatment decisions. This document becomes effective upon its proper execution and remains valid unless revoked. Upon being presented with this advance instruction, the physician or other provider must make it a part of the person's medical record. The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the advance instruction when the person is determined to be incapable, unless compliance is not consistent with G.S. 122C-74(g). The physician or other mental health treatment provider shall promptly notify the principal and, if applicable, the health care agent, and document noncompliance with any part of an advance instruction in the principal's medical record. The physician or other mental health treatment provider may rely upon the authority of a signed, witnessed, dated and notarized advance instruction, as provided in G.S. 122C-75.)

I, _____, being an adult of sound mind, willfully and voluntarily make this advance instruction for mental health treatment to be followed if it is determined by a physician or eligible psychologist that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means the process of providing for the physical, emotional, psychological, and social needs of the principal. "Mental health treatment includes electroconvulsive treatment (ECT), commonly referred to as "shock treatment", treatment of mental illness with psychotropic medication, and admission to and retention in a facility for care or treatment of mental illness.

I understand that under G.S. 122C-57, other than for specific exceptions stated there, mental health treatment may not be administered without my express and informed written consent or, if I am incapable of giving my informed consent, the express and informed consent of my legally responsible person, my health care agent named pursuant to a valid health care power of attorney, or my consent expressed in this advance instruction for mental health treatment. I understand that I

may become incapable of giving or withholding informed consent for mental treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

_____

_____.

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding psychoactive medications are as follows: *(Place initials beside choice.)*

_____ I consent to the administration of the following medications:

_____

_____ I do not consent to the administration of the following medications:

_____

Conditions or limitations: _____

_____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding admission to and retention in a health care facility for mental health treatment are as follows: *(Place initials beside choice.)*

_____ I consent to being admitted to a health care facility for mental health treatment. My facility preference is

_____.

_____ I do not consent to being admitted to a health care facility for mental health treatment.

This advance instruction cannot, by law, provide consent to retain me in a facility for more than ten (10) days.

Conditions or limitations: _____

_____

ADDITIONAL INSTRUCTIONS

These instructions shall apply during the entire length of my incapacity. In case of mental health crisis, please contact:

1. Name: _____

   Home Address: _____

   Home Telephone Number: _____

   Work Telephone Number: _____

   Relationship to Me: _____

2. Name: _____

   Home Address: _____

   Home Telephone Number: _____

   Work Telephone Number: _____

   Relationship to Me: _____

3. My Physician:

   Name: _____

   Telephone Number: _____

4. My Therapist:

   Name: _____

   Telephone Number: _____

The following may cause me to experience a mental health crisis:

_____

The following help me avoid a hospitalization:

_____

I generally react to being hospitalized as follows:

_____

Staff of the hospital or crisis unit can help me by doing the following:

_____

I give permission for the following person or people to visit me:

_____

Instructions concerning any other medical interventions, such as electroconvulsive (ECT) treatment (commonly referred to as "shock treatment"):

_____

Other instructions:

_____

_____

_____ *(Initial if applicable)* I have attached an additional sheet of instructions to be followed and considered part of this advance instruction.

SHARING OF INFORMATION BY PROVIDERS

I understand that the information in this document may be shared by my mental health treatment provider with any other mental health treatment provider who may serve me when necessary to provide treatment in accordance with this advance instruction.

Other instructions about sharing of information:

_____

_____

SIGNATURE OF PRINCIPAL

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full impact of having made this advance instruction for mental health treatment.

_____ _____

Date Signature of Principal

NATURE OF WITNESSES

I hereby state that the principal is personally known to me, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in my presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that I am not:

a. The attending physician or mental health service provider or an employee of the physician or mental health treatment provider;

b. An owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident; or

c. Related within the third degree to the principal or to the principal's spouse.

AFFIRMATION OF WITNESS

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is:

a. A person appointed as an attorney-in-fact by this document;

b. The principal's attending physician or mental health service provider or a relative of the physician or provider;

c. The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or

d. A person related to the principal by blood, marriage or adoption.

Witnessed by:

_____	_____
Witness	Witness
_____	_____
Date	Date

STATE OF NORTH CAROLINA

COUNTY OF _____

CERTIFICATION OF NOTARY PUBLIC

I, _____, a Notary Public for the County cited above in the State of North Carolina, hereby certify that _____ appeared before me and swore or affirmed to me and to the witnesses in my presence that this instrument is an advance instruction for mental health treatment, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that _____and _____ _____, witnesses, appeared before me and swore or affirmed that they witnessed _____sign the attached advance instruction for mental health treatment, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing they were not (i) the attending physician or mental health treatment provider or an employee of the physician or mental health treatment provider and (ii) they were not an owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident, and (iii) they were not related within the third degree to the principal or to the principal's spouse. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the _____ day of _____, 20_____.

_____

Notary Public

My Commission Expires:_____

I signed this notarial certificate on _____ according to the emergency video notarization

Date

requirements contained in G.S. 10B-25.

Notary Public location during video notarization: _____ County

Stated physical location of principal during video notarization: _____County

STATE OF NORTH CAROLINA

COUNTY OF _____

HEALTH CARE POWER OF ATTORNEY

NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

EXPLANATION: *You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.*

This document gives the person you designate as your health care agent ***broad powers*** *to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.*

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. ***Do not sign this form until*** *two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State:* http://www.sosnc.gov.

1. Designation of Health Care Agent.

I, _____, being of sound mind, hereby appoint the following person(s) to serve as my health care agent(s) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent(s) shall serve alone, in the order named.

A. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

B. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

C. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

2. Effectiveness of Appointment.

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physician(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

1. _____ *(Physician)*

2. _____ *(Physician)*

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my attending physician.

3. Revocation.

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

4. General Statement of Authority Granted.

Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.

B. Employing or discharging my health care providers.

C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.

D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.

E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."

F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

G. Authorizing the withholding or withdrawal of life-prolonging measures.

H. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney.

I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.

J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

5. Special Provisions and Limitations.

(Notice: The authority granted in this document is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care treatment or service. If you wish to limit the scope of your health care agent's powers, you may do so in this section. If none of the following are initialed, there will be no special limitations to your agent's authority.)

	A. <u>Limitations about Artificial Nutrition or Hydration</u>: In exercising the authority to make health care decisions on my behalf, my health care agent:
_____ (Initial)	Shall NOT have the authority to withhold artificial nutrition (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:
_____ (Initial)	Shall NOT have the authority to withhold artificial hydration (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:
	NOTE: If you initial either block but do not insert any special provisions, your health care agent shall have NO AUTHORITY to withhold artificial nutrition or hydration.

_____ (Initial)	B. Limitations Concerning Health Care Decisions. In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: your own definition of when life-prolonging measures should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or are unacceptable to you for any other reason.)
	NOTE: DO NOT initial unless you insert a limitation.
_____ (Initial)	C. Limitations Concerning Mental Health Decisions. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to following special provisions: (Here you may include any specific provisions you deem appropriate such as: limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you.)
	NOTE: DO NOT initial unless you insert a limitation.
_____ (Initial)	D. Advance Instruction for Mental Health Treatment. (Notice: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment):
	NOTE: DO NOT initial unless you insert a limitation.
_____ (Initial)	E. Autopsy and Disposition of Remains. In exercising the authority to make decisions regarding autopsy and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding burial or cremation):
	NOTE: DO NOT initial unless you insert a limitation.

6. Organ Donation.

To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

_____ (Initial)	donate any needed organs or parts; or
_____ (Initial)	donate only the following organs or parts: _____
	NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE.
_____ (Initial)	donate my body for anatomical study if needed.
_____ (Initial)	In exercising the authority to make donations, my health care agent is subject to the following special provisions and limitations: (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding gifts of the body or body parts.) _____
	NOTE: DO NOT initial unless you insert a limitation.

NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOUR INITIALS.

7. Guardianship Provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

8. Reliance of Third Parties on Health Care Agent.

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall

have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

9. Miscellaneous Provisions.

A. Revocation of Prior Powers of Attorney. I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.

B. Jurisdiction, Severability, and Durability. This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.

C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.

E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

To legally execute this document, go to the next page and sign and date with witnesses in the presence of a notary public. Then make copies – keep the original, file a copy in your medical records, and share with treatment providers and your support network. If you go to a crisis facility or the emergency room for help, take a copy with you.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

This the _____ day of _____, 20____.

_____(SEAL)

I hereby state that the principal, _____, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____COUNTY, _____STATE

Sworn to (or affirmed) and subscribed before me this day by _____
(type/print name of signer)

_____
(type/print name of witness)

_____
(type/print name of witness)

Date: _____ _____
(Official Seal) *Signature of Notary Public*

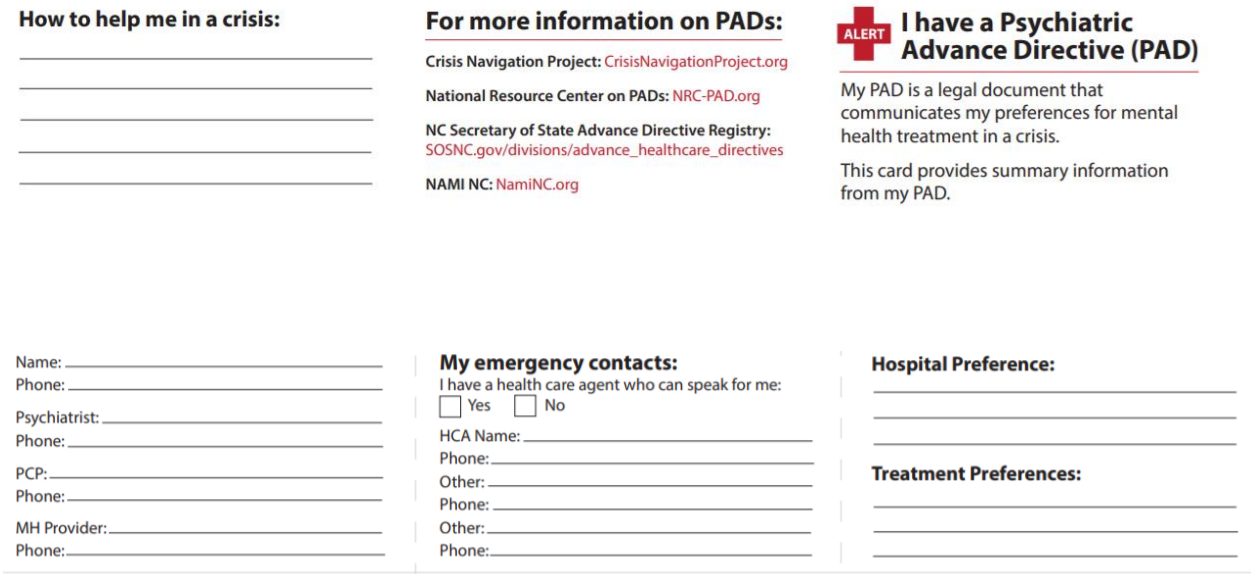
_____, Notary Public
Printed or typed name

My commission expires: _____

Wallet Card

This is a sample of a six-panel wallet card that can serve as a summary of the information in your PAD– you can find a printable PDF here: http://www.crisisnavigationproject.org/wp-content/uploads/2018/07/PADs-Wallet-Card.pdf

If you want to make your own wallet card, print the document on card stock, double-sided, and then cut and fold it into thirds.



How to help me in a crisis:

_____

_____

_____

_____

_____

For more information on PADs:

Crisis Navigation Project: CrisisNavigationProject.org

National Resource Center on PADs: NRC-PAD.org

NC Secretary of State Advance Directive Registry: SOSNC.gov/divisions/advance_healthcare_directives

NAMI NC: NamiNC.org

ALERT **I have a Psychiatric Advance Directive (PAD)**

My PAD is a legal document that communicates my preferences for mental health treatment in a crisis.

This card provides summary information from my PAD.

Name: _____
Phone: _____

Psychiatrist: _____
Phone: _____

PCP: _____
Phone: _____

MH Provider: _____
Phone: _____

My emergency contacts:

I have a health care agent who can speak for me:

☐ Yes ☐ No

HCA Name: _____
Phone: _____
Other: _____
Phone: _____
Other: _____
Phone: _____

Hospital Preference:

_____

_____

_____

Treatment Preferences:

_____

_____

_____

In North Carolina, you can also store your fully executed psychiatric advance directive (signed, witnessed and notarized) at a secure online repository at the NC Secretary of State's website: https://www.sosnc.gov/divisions/advance_healthcare_directives. To store your PAD here, you must mail a hard copy (keep your original in a safe place!) with a $10 fee. Your documents will then be uploaded into a secure repository and you will be mailed a wallet card with a username and password and instructions how to access your documents anywhere you can access the internet.