GOLDEN WILLOW
COUNSELING

412 Sipapu, Taos, NM 87571
575-770-9513

24 Hour Crisis Intervention Services:

- NM Suicide & Crisis Hotline (Statewide 24 hours – 7 days a week Crisis Line):
  1-800-SUICIDE (784-2433)

- Peer to Peer WARMLINE (Statewide): 1-800-466-7100
  Call 7 days a week from 3:30 pm to 11:30 pm
  Text 7 days a week from 6:00 pm to 11:00pm

- New Mexico & Crisis Hotline 24 hours a day – 365 days a year (Statewide):
  1-855-NMCRISIS (622-7474)

- Local Emergency
  911

GOLDEN WILLOW
COUNSELING

Table of Content

Rules and regulations for my conduct at Golden Willow Counseling

1. I will show up on time for treatment sessions. If I am not able to attend, I will call as soon as possible to explain my absence.
    a. All absences are reported to referral sources.
    b. Only absences due to death of an immediate family member or for illness (self or dependent) **WITH A MEDICAL PROVIDER'S NOTE** are excused.
2. I agree to abstain from the use of all drugs and alcohol unless prescribed by a medical provider.
3. I agree to comply with the program's policies and rules on medications. Only prescribed by your medical provider with dosing information are allowed, and **only if you notify us of their use and provide a release to speak with your medical provider**.
4. I understand that violence or threats of violence to staff, property, or other clients may result in immediate discharge from the program and notification to law enforcement.
5. I will avoid offensive language or behavior during treatment, and treat all persons with respect and courtesy.
6. I agree to maintain confidentiality of any information discussed in groups. I know that the clinical staff will share information with the rest of the treatment team.
7. I understand that staff is required to report suspected child abuse or neglect, any threats to harm myself or another person, and abuse or neglect of the elderly.
8. I will follow the approved grievance procedure in the event of a conflict.
9. I understand that should I not comply with any of the program's policies, I may be discharged from the program.

Attendance and reporting of non-compliance

To be in good standing with the Program, you must attend scheduled activities.

Excused absences are for medical reasons (doctor's note required) or in the even of death of a close relation.

Work or childcare-related absences are generally considered unexcused. Exceptions may be made as authorized in writing by referring agency or the Executive Director.

Three consecutive absences and/or inconsistent attendance (a series of single unexcused absences) shall result in automatic notification of the Court (where applicable).

a. All absences are reported to referral sources.
b. Only absences due to death of an immediate family member or for illness (self or dependent) **WITH A MEDICAL PROVIDER'S NOTE** are excused.

Drug and alcohol testing and reporting of results

I understand that it is the policy of GWC to test all clients for alcohol and/or drugs periodically.

These test results are regularly reported to referral sources. I understand that by signing this consent to be treated, I am agreeing to abide by all rules of GWC governing the uses of the results of this test.

- I understand that refusal to provide test samples will be considered "positive, client refused" and will be reported to my referral source.
- I understand that statement that "I am not able to provide a sample now" (for any reason) will be considered "positive, client refused" and will be reported to my referral source.
- I understand that missing a random test from the call-in system or leaving the facility to avoid a test will be considered "positive, client refused" and will be reported to my referral source.
- Not notifying staff of changes to prescribed medications will be considered "positive, client refused" and will be reported to my referral source.

Program activities and topics

Treatment Planning

Each client shall develop in conjunction with his/her primary counselor an Individual Service Plan that:

1. Is based on data from the assessment process and documents the need for IOP/OP services
2. Reflects current client status and Stage of Change
3. Includes client identified needs and desires for the treatment experience
4. Features interventions that are specific, behavioral, and time-phased
5. Addressed all behavioral health concerns
6. Includes information about other providers involved in the case, where appropriate, and efforts to coordinate or integrate treatment
7. Is linguistically and culturally appropriate
8. Incorporates recover/resiliency values

Client and counselor shall sign and date the completed plan, and the client shall receive a copy. The original shall be kept in the client record. The treatment planning process is described in a separate policy.

The treatment plan shall be reviewed as necessary during the course of treatment and also when there is significant change in client status. The treatment plan shall include relevant information concerning services provided by other agencies or providers. Review of the treatment plan shall be documented in the client record, through signature and date of review.

Treatment Modalities

GWC treatment services are rooted in industry best practices and evidence-based methodologies, particularly the Matrix Model for adult treatment. Approved treatment curricula and materials shall be available for review and reference at each site. Personnel files reflect training in the GWC treatment model of choice.

Group Therapy

Groups at GWC may be task-centered or open discussion. The ideal group size is 12 members, not to exceed 15. Group participation shall be documented in the progress notes of the client record. Group sessions feature cognitive-behavioral strategies and interventions such as those represented in the Matrix Model.

Individual Therapy

Individual sessions are scheduled in accordance with the individual plan. IOP clients receive a minimum of two individual sessions with the counselor per month. Additional sessions are available based on identified client need. Individual sessions are designed to address client needs and concerns as well as to enhance client outcomes through incorporation of motivational strategies.

Clinical Supervision

GWC clinical supervisory staff are licensed independent practitioners with a minimum of two years experience with alcohol/drug clients and persons with co-occurring disorders, including at least one year of supervisory experience. Expertise in both substance and mental health disorder is required.

Clinical supervision occurs through scheduled clinical staffing sessions where cases are presented by primary counselors and reviewed with the licensed supervisor. Counselors have the opportunity to seek input on client progress and to seek advice about further treatment interventions. Modifications in the treatment plan based on these reviews shall be documented in the client record. The supervisory process is documented by signature of the Clinical Supervisor along with licensure information and time and date of the review.

Discharge Planning

The planning process is initiated during development of the individual service plan and continues throughout the course of treatment at GWC. Discharge planning is documented in the client record and culminated in the Discharge Plan and with referral to continuing care. The discharge planning process is described in a separate policy.

Discharge Summary

A discharge summary describing the course of treatment, any referral or recommendations for continuing care, and a likely prognosis shall be completed by the primary counselor for inclusion in the client record. Recommendations for further treatment or services shall be documented, along with referral information, in the client record. The Summary shall document any post-treatment appointments made by the counselor on behalf of the client. The discharge summary is described in a separate policy.

It is the policy of GWC to provide research-focused, evidence-based group and individual counseling to all clients. The core program shall be drawn from the Matrix Model for adults. Supplemental activities may be derived from current best practices in cognitive-behavioral therapy, motivational enhancement, and the 12 Step Facilitation approaches. Activities and techniques used in GWC treatment sessions shall be approved by the GWC licensed clinical supervisory staff prior to use in the program. A reference manual of program materials shall be maintained at each site.

Individual Sessions

Individual therapy sessions shall occur at minimum once per week (OP) or twice monthly (IOP) or as needed, and shall be focused on issues of importance to client recovery. Motivational strategies shall be employed to facilitate advances through the stages of client change. The focus of individual sessions shall depend on assessed client need and may include skill building activities with respect to: anger management; relapse prevention/refusal skills; conflict resolution skills; interpersonal relationships and communication skills; stress management skills; assertiveness training; adaptive daily living/coping skills; parenting skills practices; mood management and emotional regulation; self-modification of behaviors/skill building to control craving; career planning/educational goals (if applicable); money/budget management; gender specific issues; domestic violence/education prevention; issues of cultural sensitivity; family roles and dynamics in addictions; other activities as needed to address individual's goals and objectives for continued growth.

Individual sessions shall be documented in the Progress Notes. The status of any preventive services such as relapse prevention or stress management shall be documented within six months of enrollment at GWC.

Group Sessions

Groups are based on the Matrix Model of treatment. Other methods may be incorporated to build needed skills and/or enhance the client's experience of treatment.

Groups are designed so that clients may enter the program at any time in the group cycle.

Rules for conduct in the group, including maintenance of client confidentiality, shall be posted in the group meeting room.

Groups should occur as the appear on the schedule of activities. Attendance records shall be kept.

Groups may be task-centered (focused on a specific topic or treatment objective) or open discussion (without a designated task and free to move where clients wish).

Group tasks may include among others: Life skills such as anger management; conflict resolution and stress reduction; relationship, family, and patenting issues; 12 Step work, relapse prevention; gambling or compulsive sexual behavior.

A group progress note shall be prepared for each group session.

Clients that are excused from attendance for more than two weeks should meet with their counselor prior to attending group therapy, for purposes of updating the treatment plan.

Client Education

Reflecting the Matrix Model of treatment, clients and (where available) interested family members shall be educated regarding a variety of topics related to recovery from addiction and co-occurring disorders. This education may occur in group or individual sessions or through provision of the informational materials to clients and families. Educational content shall reflect current best practices and evidence-based treatment methods as approved for use by qualified clinical supervisors. Client and family education shall be documented in the client record.

Education topics shall include treatment planning, discharge planning, community-based support, behavioral health problems, and options for continuum of care.

Family Sessions

GWC holds that positive, supportive participation by family and concerned persons can improve outcomes and significantly increase the likelihood of stable recovery. Therefore, family member(s) and/or concerned persons are urged to attend scheduled educational sessions targeted toward their needs and role in recovery. Informational materials for families, including a basic recovery workbook, shall be made available through GWC.

Family sessions shall cover topics of interest to family and concerned persons such as:

Avoiding; enabling, coping with relapse; improving communications; finding support in recovery; parenting and child development.

Where needed, client and counselor may request that family and/or concerned persons attend individual sessions. In that even, the family member(s) and concerned persons shall be asked to sign appropriate documentation regarding client confidentiality.

It is the policy of GWC to encourage involvement of family members and concerned persons in the client's treatment, and to take steps to assist families in promoting the goals of recovery.

Voluntary and Involuntary Termination from the Program

Termination from the program

You are free to discharge yourself from the program at any time. Inform your primary counselor and a referral to other services can be made if necessary.

The following can result in involuntary termination from the program:

1. Using or possessing drugs or alcohol on the premises
2. Violence or threats of violence, or possession of any weapons
3. Attempted alteration of a urine sample to avoid discovery
4. Non-payment of required treatment fees

Medication Policies

Smoking

The program prohibits smoking beyond designated (posted) smoking areas.

Prescribed Medications

You should inform your counselor of any prescription medications you are taking so as to ensure it does not cause a positive drug test result or otherwise interfere with recovery.

Mental Health Care and Medication Management

During the course of treatment, GWC clinical staff shall coordinate with the CSA for provision of mental health services, including but not limited to assessment, medication management, and crisis management. GWC shall provide necessary clinical information and shall work cooperatively with CSA clinical staff to facilitate the delivery of care. GWC clinical staff shall receive training in mental health issues and services.

Medicaid Rights

For Medicaid Eligible Clients:

The New Mexico Human Services Division has established an administrative process to provide a Fair Hearing for eligible Medicaid recipients. This includes a grievance resolution process. NMAC 8.310.14.13.

You may contact Optum Health New Mexico at 1.866.660.7185 at any time for confidential help.

Client Rights and Responsibilities

The program shall ensure that all clients:

1. Are admitted to treatment without regard to race, color, creed, national origin, religious preference, gender, sexual orientation, age, or disability.
2. Receive reasonable accommodation of sensory or physical disability. This includes limitations on English proficiency, ability to communicate, and cultural beliefs and background.
3. Are treated with sensitivity to individual needs and differences.
4. Are treated in a manner that promotes dignity and self-respect. This includes the need for privacy in clinical situations and drug testing practices.
5. Are involved in the various aspects of treatment planning, including discharge and transition planning, treatment termination, and other clinical processes.
6. Are protected from invasion of privacy. Program staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises.
7. Are given the right to refuse participation in any experimental or investigative research without written and informed consent.
8. Receive due protection of clinical and personal information in accordance with applicable Federal and State regulations concerning client confidentiality.
9. With reasonable notice, may review their treatment records in the presence of the clinical staff.
10. May know the name, credentials, and professional status of persons providing services.
11. Are fully informed regarding fees and payment for services, including options for payment and any fees for copying or sending records at the client's request.
12. May practice personal religious and spiritual preferences so long as they do not infringe on the rights of others or interfere with treatment at the clinic.
13. Are protected from abuse by staff or other clients, including physical violence, emotional or verbal abuse, sexual or financial exploitation, racial prejudice, and harsh discipline or punishment.
14. Are provided with a copy of the grievance procedure on request.
15. In the event of a clinic closure, receive adequate notice, assistance with relocation, provided with eligible refunds, and advice on access to client records in future.
16. Are entitle to written consent for all forms of release of protected information. This consent shall include:

- Name & title of person or organization to who information is to be released.
- Nature of information to be disclosed, and purpose of disclosure.
- Date or event when consent is to expire.
- Acknowledgement of client's right to revoke consent.
- Signature and dates.
- Statement prohibiting further disclosure without additional consent.

A copy of this client's rights is given to each person receiving services at admission and in the event of disciplinary discharge. A copy is posted in a conspicuous place accessible to patients and staff.

Coordination of Care

It is the policy of GWC to provide coordinated, concurrent services for all clients. Consumers with co-morbid mental health and substance disorders will have coordination of care through the formation of a Treatment Team involving the area Core Services Agency (CSA). GWC has signed a memorandum with the CSA to achieve the following:

- Coordination of care for clients with co-occurring disorders, including regular scheduled meetings to review the comprehensive plan of care.
- Provide consumers with high-quality services that are client-centered, culturally competent, and family-focused.
- Identify formal and informal supports to aid clients in recover, including linkages with helpful services in the community.
- Ensure clients are able to access needed services in several domains without undue delay.

Charitable Choice/ Religious

GWC is not affiliated with any church, religious denomination, or religious group, and shall notify prospective clients of this via posted notice in public areas at all sites.

Clients who prefer a provider of a particular religious affiliation shall be referred elsewhere by GWC staff. Referrals made for this reason shall be documented in the client record.

Grievance and Appeal Procedure

All clients are provided with the grievance procedure. A copy of that form is included following this section. We will also provide this form to any client or family member upon request.

1. Client or family shall complete a Grievance Form and submit to GWC administrative or clinical staff.
2. The Form is reviewed by administration. Additional information may be requested of the client as needed. The purpose of the review is to determine possible resolutions for the issues involved in the grievance.
3. A response in writing shall be provided to the client within 5 business days of the filing of the grievance.
    a. If the client is unsatisfied with the outcome, he/she may request a meeting with the Executive Director to review the issues.
    b. If the client remains unsatisfied following this meeting, he/she may contact the New Mexico ombudsperson at 505.827.6250 for further assistance.

Golden Willow Counseling

Client Appeal (Grievance) Form

Client Name: _____ Date of Incident: _____

Client Address: _____ Telephone #: _____

_____

Type of Grievance:

Patient Rights _____ Ethics/Code of Ethics _____ Other _____ _____

Description of Grievance:

Please provide a detailed description, including person(s), place, and time of the incident you are reporting. IF you are reporting the incident to the Division office, you will be contacted within five (5) business days from the receipt of the report to schedule a date and time to discuss the report.

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(if you need additional space to complete the report, please write on back of this form)

_____ _____

Signature of person completing the form Date

Notice of Health Information Practices

Each time you visit GWC, or any health care provider, a record of your visit is made. This record contains information about your health history and treatment. This information is used to:

- Plan your care
- Communicate among those who contribute to your care
- Serve as a legal document describing the care you received
- Means by which you or a third-party payer can verify the services billed were actually provided
- Educate health professionals
- Provide a source of data for medical research
- Help public health officials to improve the overall health of the community
- Provide data for planning
- For quality improvement activities

Your Health Information Rights

The client record belongs to the program, but you have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 and 42 CFR, Chapter 1, Part 2
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR.164.524
- Amend your health record as provided in 45 CFR.164.528
- Obtain an accounting of disclosures as provided in 45 CFR.164.528
- Request communication of your health information by alternative means or at alternative locations
- Revoke your authorization for future disclosures

Our Responsibilities; GWC must:

- Maintain the privacy of your health information
- Notify you of our legal responsibilities and privacy practices
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests to communicate personal health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied to us. We will not use or disclose your health information without your authorization, except as described in this notice.

Complaints:

If you believe your privacy rights have been violated, you can file a complaint with the Dept. of Health and Human Services/ Office for Civil Rights by mail to:

ocrcomplaint@hhs.gov or by calling the national office at 202.205.8725 and asking for the OCR Health Information Privacy Complaint Form and/or for the appropriate Regional OCR Office. There will be no retaliation for filing a complaint.

Examples of Disclosures:

- Treatment
- Requirements of the Court, or information for Continuing Care, or Referrals to other providers
- Payment
- Quality monitoring and improvement
- Emergency Care
- Communication with family members, if you consent
- Authorized research, with your consent
- Continuing care/Outcome Monitoring
- Public Health/Disease Prevention
- Law Enforcement requests per 42 CFR, Chapter 1, Part 2 (see Notice of "Confidentiality of Alcohol and Drug Abuse Patient Records")

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering you or patients, workers, or the public. In this case, a court order is required per 42 CFR, Chapter 1, Part 2.

This organization reserves the right to change the terms of its notice and to make the new notice provision effective for all protected health information that it maintains. Revisions of this notice will be posted at this location and on the organization's website.

Reference: *Health Insurance Portability and Accountability Act (45 CFR Part 160-164) HIPPA Privacy Rule-* ***Standards for Privacy of Individuality Identifiable Health Information*** *adapted from the American Health Information Management Association Practice Brief, "Notice of information Practice" (Updated November 2002); and 42 CRF, Chapter 1, Part 2: Confidentiality of Alcohol and Drug Abuse Patient Records*

Psychiatric Advance Directives

Why should I fill out a Psychiatric Advance Directive?

(or, sometimes the best defense is a good offense)

An advance directive spells out what you want done in a time of crisis as a result of your mental illness. It enables you to choose who you want to make mental health treatment decisions for you. It can also let others know your plans for the care of your children, pets, or home. This directive does not "activate" unless your capacity to make mental health treatment decisions becomes impaired. You can also use this document to describe those behaviors which are "indicators" of impaired capacity which you think might activate the advance directive. An advance directive helps you maintain control in a time of mental health crisis and may prevent the crisis from worsening. Here are a number of important reasons why consumers should consider completing advance directives for mental health care:

1. An advance directive helps you maintain choice and control in the treatment you receive, according to your knowledge of what works best for you in managing your mental health care. This includes medication and treatment you do and do not want.
2. An advance directive increases the possibility that there will be continuity of care in times of crisis, including place, type, and personnel involved in treatments.
3. An advance directive may decrease the possibility of involuntary treatment.
4. If involuntary treatment does occur, a mental health care directive should have a direct impact on the treatment you do receive, including times in the hospital, the use of mediations, place of treatment, and treatment plan upon release.
5. Preparing a mental health care directive creates an excellent opportunity to develop an effective crisis intervention plan and to discuss it with family, friends, treatment professionals, and others before a crisis arises. This includes the opportunity to discuss approaches that are effective and those that hinder, rather than help, in times of crisis.
6. An advance directive allows you to authorize the release of information at a time when your capacity to make authorization is clear. It also enables you to state whom you do and do not want notified at the time of hospitalization.
7. An advance directive, particularly the appointment of an agent who your trust, can be an effective alternative to the court-appointed guardian.
8. An advance directive can include how you want your family, pets, and finances cared for while you are receiving treatment.
9. The implementation of an advance directive can help restore self-confidence and allay fears and panic in a time of crisis. This helps in terms of stabilization and recovery.
10. New Mexico does not require you to fill out a specific form. It does require: 1) You must sign the advance directive. 2) You must have it witnessed and, if you wish, have it notarized. 3) If you appoint an agent, have the agent sign that he/she is accepting the appointment. It is helpful to have this as part of your advance directive.

New Mexico HB-459

Optional Form for Advance Directive for Mental Health Treatment

1. The following form may be used to create an individual instruction regarding mental health treatment. An individual may complete or modify all or part of the form. The Mental Health Care Treatment Decisions Act governs the effect of this or any other writing used to create an advance directive for mental health treatment.

2. A principal may designate a capable person eighteen years of age or older to act as an agent to make mental health treatment decision. An alternative agent may also be designated to act as an agent if the original agent is unable or unwilling to act at any time. An appointment of an agent may be accomplished by using the form provided.

3. An agent who has accepted the appointment in writing shall have authority to make decision, in consultation with the primary health care professional, about mental health treatment on behalf of the principal only when the principal is certified to lack capacity and to require mental health treatment as provided by the Mental Health Care Treatment Decisions Act. These decisions shall be consistent with any wishes or instructions the principal has expressed in the instruction. If the wishes or instructions the principal are not expressed, the agent shall act in what the agent believes to be the best interest of the principal. The agent may consent to evaluation for admission to inpatient mental health treatment on behalf of the principal, if so authorized, in the advance directive for mental health treatment.

4. An agent may renounce the agent's authority by giving notice to the principal. If a principal lacks capacity, the agent may renounce the agent's authority by giving notice to the named alternative agent, if any, or, if none, to the attending qualified health care professional or health care provider. The primary health care professional or health professional or health care provider shall note the withdrawal of the last named agent as part of the principal's medical record.

5. An advance directive for mental health treatment may be executed by using the following optional form, completed or modified to the extent desired by the individual, and the form may be notarized.

Advance Directive for Mental Health Treatment

I, _____, being a person with capacity, willfully and voluntarily make known my wishes about mental health treatment, by my instructions to others through my advanced directive for mental health treatment, or by my appointment of an agent, or both. If a guardian or an agent is appointed to make mental health decisions for me, I intend this document to take precedence over other means of ascertaining my wishes and interests. The fact that I may have left blanks in this directive does not affect its validity in anyway. I intend that all completed sections be followed. I intend this directive to take precedence over any other mental health directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document. I understand that I cannot revoke this directive if one qualified healthcare professional and one mental health treatment provider find that I am an incapacitated person, unless I successfully challenge the determination of incapacity.

I understand there are some circumstances where my provider may not have to follow my directive specifically, if the treatment requested in this directive is infeasible or unavailable, the facility or provider is not licensed or authorized to provide the treatment requested or the directive conflicts with other applicable law. I thus do hereby declare:

I. Declaration for Mental Health Treatment

If a mental health treatment provider and a qualified health care professional, one of whom is my primary health care professional, if reasonably available, determine 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 and that mental health treatment is necessary, I direct my primary health care professional and a mental health treatment provider, pursuant to the Mental Health Care Treatment Decisions Act, to provide the mental health treatment. I have indicated below by my signature, I understand that "mental health treatment" means services provided for the prevention of, amelioration of symptoms of, or recovery from mental illness or emotional disturbance, including but not limited to electroconvulsive treatment, treatment with medication, counseling, rehabilitation services, or evaluation for admission to a facility for care or treatment of persons with mental illness, if required.

Preferences and Instructions About Treatment, Facilities, and Physicians

I would like the physician(s) named below to be involved in my treatment decisions:

Dr. _____ Contact Info _____

Dr. _____ Contact Info _____

I do not wish to be treated by Dr. _____

Other preferences: _____

_____

Preferences and Instructions About 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 the directive is effective:

Name: _____ Profession: _____

Contact Information: _____

Name: _____ Profession: _____

Contact Information: _____

Preferences and Instructions About Mental Health Treatment (initial and complete all that apply)

_____ I consent and authorize my agent to consent to the following medications:

_____

_____ I do not consent and I do not authorize my agent 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.

Pick one of the following:

_____ I am willing to try any other medications the hospital doctor recommends.

_____ I am willing to try any other mediations my outpatient doctor recommends.

_____ I do not want to try any other medications.

Medication Allergies

I have allergies to, or severe side effect from the following:

_____

I have the following other preferences or instructions about mediations:

_____

Preferences and Instructions About Hospitalization and Alternatives

(initial all that apply and, if desired, rank "1" for first choice, "2" for second choice, etc.)

_____ 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 hospitalization.

_____ I would like the interventions below to be tried before hospitalization is considered:

_____ Calling someone or having someone call me when needed.

Name: _____ Telephone: _____

_____ 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 provider for help with psychiatric medications.

_____ Other (Specify): _____

Authority to Consent to Inpatient Treatment

I consent, and authorize my agent to consent, to evaluation for admission to inpatient mental health treatment:

_____ If deemed appropriate by my agent and treating physician

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

_____

_____ I do not consent, or authorize my agent to consent, to evaluation for admission to inpatient treatment.

Preferences and Instructions About Use of Seclusion or Restraint

I would like the interventions below to be tried before use of seclusion or restraint is considered. (initial 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; specify _____

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, etc.)

_____ Seclusion

_____ Seclusion and physical restraint (combined)

_____ Medication by injection

_____ Medication in pill or liquid form

In the event my physician 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 this directive. The preferences and instructions I have expressed in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

Preferences and Instructions About Electroconvulsive Therapy

My wishes regarding electroconvulsive therapy are (sign one):

_____ I do not consent, nor authorize my agent to consent, to the administration of electroconvulsive therapy.

_____ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy.

_____ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

_____

Preferences and Instructions About Who is Permitted to Visit

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

Name: _____ Name: _____

Name: _____ Name: _____

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

Additional Instructions About My Mental Health Care

Other Instructions about my mental health care: _____

_____

In case of an emergency, please contact:

Name: _____

Address: _____

Work Telephone: _____ Cell Phone: _____

Physician: _____ Phone: _____

Address: _____

The following may help me to 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;

_____

_____

_____

Refusal of Treatment

I do not consent to any mental health treatment.

_____

Signature

I further state that this document and the information contained in it may be released to any requesting licensed mental health professional.

_____ _____

Signature of Principal Date

_____ _____

Signature of witness Date

II. Appointment of Agent

If my primary health care professional and a mental health provider determine 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 and that mental health treatment is necessary, I direct my primary health care professional and other health care providers, pursuant to the Mental health Care Treatment Decisions Act, to follow the instructions of my agent.

I hereby appoint:

Name: _____

Address: _____

Telephone: _____

to act as my agent to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my agent, I authorize the following person to act as my agent:

Name: _____

Address: _____

Telephone: _____

My agent is authorized to make decisions that are consistent with the wishes I have expressed in my declaration. If my wishes are not expressed, my agent is to act in what he/she believes to be my best interest.

_____ _____

Signature Date

III. Conflicting Provision

I understand that if I have completed both a declaration and have appointed an agent and if there is a conflict between my agent's decision and my declaration, my declaration shall take precedence unless I indicate otherwise.

_____

Signature

I understand that if I have completed both an advance directive health care directive and an advance directive for mental health treatment, that those directives should be executed as separate instructions.

_____

Signature

IV. Other Provisions

1. In the absence of my ability to give directions regarding my mental health treatment, it is my intention that this advance directive for mental health treatment shall be honored as the expression of my legal right to consent or to refuse to consent to mental health treatment.
2. I direct the following concerning the care of my minor children:

   _____
   _____
   _____
3. This advance directive for mental health treatment shall be in effect until it is revoked.
4. I understand that I may revoke this advance directive for mental health treatment at any time.
5. I understand and agree that if I have any prior advance directives for mental health treatment, and if I sign this advance directive for mental health treatment, my prior advance directives for mental health treatment are revoked.
6. I understand the full importance of this advance directive for mental health treatment and I am emotionally and mentally competent to make this advance directive for mental health treatment.

Signed this _____ day of _____, 20____

_____ _____

Signature City, County, and State of Residence

This advance directive was signed in my presence.

_____ _____

Signature of Witness City, County, and State of Residence