Mental Health Supportive Care Plan with Checklists (v1)

Advance Life Care Planning/Supportive Care Pilot Project
Older Adult Team – Behavioral Health Division (OAT/BHD) – County of Sonoma

Your Name (print)_____
Phone_____ **Date**_____

Name/Agency/Contact Information for person helping me to complete this, if applicable.
Name/Agency_____Phone_____

Introduction/Plan Overview:

No matter what our health problems may be, it is important that we are all recognized and respected as being the best source of information about ourselves and what is important to us. This plan can assist you to get the best possible care and support that is based on your values and preferences.

If you are unable to make decisions or communicate for yourself, this plan would help guide people you trust, your designated Health Care Agent and health professionals when providing your needed care and support. It will help you direct them to make every effort to honor your wishes. Sometimes, this may not be possible, due to limitations of a conservatorship if you are conserved, or because of lack of resources, such as placement at your preferred place of hospitalization.

If there is anything you do not care to answer, please draw a line through that section and initial on the line you draw as your response.

Allergy Alert: _____

_____

Medications Alert: I have an allergic or bad reaction and/or severe side effects to the following medication (If possible describe the adverse medication effects):_____

_____

_____

_____

Please see item 8 for more details regarding medication preferences.

1. Emergency Contacts:

My doctor and mental health care team include (names, titles and contact information):

Name_____Title_____Phone_____
Name_____Title_____Phone_____
Name_____Title_____Phone_____

2. I have an Advance Health Care Directive (Advance Directive) designating who I want to make mental health care decisions if I am unable to do that. ___Yes ___No

<u>If Yes</u>, here is my Health Care Agent information:

Agent Name_____Relationship_____Phone_____

Alternate 1 Agent Name _____Relationship _____Phone_____

Alternate 2 Agent Name _____Relationship _____Phone_____

<u>If No</u>, would you like help completing an Advance Directive? ___Yes __No

3. For me, these things may trigger a mental health crisis:

__change of routine __travel __missed medications
__negative thinking __ feeling isolated __physical illness
__ family problems __death of a loved one __being or feeling traumatized
__being institutionalized e.g. hospital, jail, etc. __being or feeling verbally or physically abused
__ news upsetting to me __ violence __loss, e.g. housing, relationships, possessions, etc.
__other/please explain: _____
_____

4. Early warning signs that I may be heading towards a mental health crisis may include:

__mounting & escalating anxiety __sleep problems/insomnia __guilt and shame
__off medications __depression __paranoia __suicidal thoughts __social isolation
__overeating or undereating __loss of hope and giving up __self-harm
__hearing voices __hard time communicating __can't stop crying __agitation
__having hallucinations __delusional thinking __changes in substance use patterns
__other/please explain: _____
_____

5. Things that are difficult for me that could make my crisis worse include:

__abrupt change in routine __ threatening environment __hospitalization __depression
__feeling alone with no support for my needs __people rushing around me
__ others pushing religion on me __people making assumptions about me __stigma

__not feeling respected __ not being given choices __people having power over me
__lack of transportation and/or support resulting in inability to access services __trauma
__being restrained or in seclusion __ forced medication __suicidal thoughts
__being away from loved ones __dealing with family __increase in physical symptoms
__not being listened to __not being informed about my care __take downs
__other/please explain: _____
_____

6. Things that help ease my distress and give me comfort include:
__feeling cared about and valued with my beliefs, values and preferences respected
__someone just being with me __being in a quiet place __writing things down for me
__recognizing that I am an important source of information and experience __a hug
__recognizing and accommodating my cultural, literacy and/or disability issues
__explaining and demonstrating a procedure before it is performed on me
__being listened to and heard __having choices __doing activities to keep me occupied
__friendly helpful staff __not being touched __things that make me feel safe
__other/please clarify e.g. certain people, music, art, book, stuffed animal. . .
These are some other things that could help me:_____
_____

7. What is the best way to approach you to offer help if you are having a mental health crisis?_____
_____

8. My Medication Preferences for Treatment in a Mental Health Crisis:
Medications I want to receive and why:_____
_____
_____
Medications I do not want to receive and why:_____
_____
_____
(Please attach your current list of medications and medication history if available)

9. My Treatment Preferences in a Mental Health Crisis

a) Treatment I want to receive and why:_____
_____

b) Treatment I DO NOT want to receive and why:_____
_____

10. Hospitalization and Treatment Facility Preferences in a Mental Health Crisis IF I cannot think for myself and need help:

(a) Leave this decision to my Health Care Agent? __Yes __No

(b) Leave this decision to my doctor and mental health care team? __Yes __No

(c) My hospital and treatment facility preferences for a mental health crisis include:_____

_____

_____

(d) In the past I had this experience with hospitalization and/or facility treatment (Please explain): _____

_____

_____

(e) Do you want experimental treatments used? __ Yes ___No

If you answer yes, please clarify what does this mean to you and what would be acceptable:

_____

_____

_____

11. In the Emergency Room, hospital or acute psychiatric care facility, my preferences in a mental health crisis include:

__notify my Emergency Contacts immediately __use alternatives to medication

__use alternatives to forced medications or restraining me (indicated in #6 above)

Other alternatives that have been helpful to me include:_____

_____

For ECT/Shock Therapy: __ use if critical to do __don't use __my doctor can decide

Please clarify what this means to you:_____

_____

12. Other things important to know about me when I am having a mental health crisis:

_____

_____

_____

_____

13. Related care needs and issues:

___ I have ___ pets (how many?) including (what) _____ who are named_____. My pet(s) could go here or would have to be cared for if I can't take care of them. (Please Explain):_____

_____

_____

__ I have plants, valuable personal or meaningful items or collectables that need to be protected if I am unable to look after my own things (Please Explain):_____

_____

_____

__ My belongings can safely be stored here if need be (Please provide name, place and contact information if applicable):_____

_____

_____

14. Other care needs, issues, or information I would like to include (please explain):

_____

_____

_____

_____

_____

_____

_____

_____

(<u>Please add additional page if need be</u>)

15. I approve sharing my Mental Health Supportive Care Plan with:

(a) My designated Health Care Agent(s) __Yes __No
Name(s):_____

(b) Health care providers involved in my care with a need to know because they would be helpful providing needed care. __Yes __No.

(c) Other/please clarify:_____

_____

16. Have you signed a County Release of Information form for each person named who you want to have access to your Mental Health Supportive Care Plan? __Yes __No

IF NO, would you like to do that? __Yes __No

17. Signing Instructions:

To help make your Mental Health Supportive Care Plan effective, it is best that you do this as a part of your Advance Health Care Directive (AHCD). If your Mental Health Supportive Care Plan is done as a formal part of your Advance Health Care Directive (AHCD), your signature could be done and witnessed or notarized when you sign your Advance Health Care Directive. To include this as part of your AHCD, in the AHCD under "Special Instructions" or "Attachments" you would write in "See Mental Health Supportive Care Plan attached." Then you would attach your Mental Health Care Supportive Plan to the AHCD before finalizing and signing your AHCD.

If you do this separate and apart from your Advance Health Care Directive (AHCD), it is best if you can sign your Mental Health Supportive Care Plan when your signature can be witnessed by two people who meet the same witnessing requirements required to complete your Advance Health Care Directive as given below. Or you could have your signature notarized to legally prove you are the person who signed this form. This does not insure your wishes will be honored. It does prove that these are your wishes and that you want your wishes honored whenever possible.

18. YOUR SIGNATURE

This verifies that I am the person completing this Mental Health Supportive Care Plan to make my preferences known and help guide my care when I am having a mental health crisis.

YOUR SIGNATURE:

_____

Sign Your Name Date

_____

Print Your Name

_____

Address City State/Zip Code

IF YOU HAVE WITNESSES, be sure they are qualified AND make certain they together see you sign the form. Then have them complete the following.

Witness One and Witness Two Signing Promise by signing that:

(YOUR name goes in here) _____ signed this form while I watched, was thinking clearly and was not forced to sign it.

Witness One and Witness Two also promise by signing that:

- I know the person or the person could prove to me who they are.
- I am 18 years or older and I do not work where this person lives.
- I am not this person's health care provider and I do not work for this person's health care provider.

Witness Two also promises that:

I am not related to this person by blood, marriage or adoption and that I will not get any money or property after this person dies.

Witness One:	**Witness Two:**
_____	_____
Sign Your Name and Date	Sign Your Name and Date
_____	_____
Print Your Name	Print Your Name
_____	_____
Address City State/Zip Code	Address City State/Zip Code

If you do not have witnesses take your completed form to a person who is a notary public who can verify your identification and notarize your signature to complete your form. The Notary will complete a Certificate of Acknowledgement that you are the person signing this form. You will attach that completed Certificate to the form. If you need a Notary you can use the form on the next page. Instructions for Nursing Home Residents are also on next page.

User's Note: Development of the Mental Health Supportive Care Plan was facilitated by Susan Keller, MA, MLIS, Director of the Community Network for Appropriate Technologies working in collaboration with the Behavioral Health Division, County of Sonoma (BHD), the Coalition for Compassionate Care of CA (CCCC) and Goodwill Redwood Empire. For more information email skeller@pacific.net .

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses)

> A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which the certificate is attached, and not the truthfulness, accuracy or validity of that document.

State of California, County of _____.

On this _____ before me_____
(date) (insert name and title of officer)
personally appeared_____ who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of California that the foregoing paragraph is true and correct.

Title or Type of Attached Document:_____

Number of pages:_____ Date:_____

Capacity(ies) Claimed by Signer(s)
__Individual __Conservator __Other_____

Witness my hand and official seal.

Signature of Notary_____ **(Seal)**

For California Nursing Home Residents Only

If you are a nursing home resident, it is best to complete this as a part of your Advance Health Care Directive (AHCD) and note in that document: See Mental Health Supportive Care Plan Attached. Then attach this completed form to your AHCD before you sign that and follow witnessing instructions for completing an AHCD as a nursing home resident.

Signature Section prepared by Susan Keller, MA, MLIS, Director, Community Network Journey Project drawing from signing instruction for the Advance Health Care Directive in compliance with CA Probate Code, Sections 4657, 4659(c), 4670-4675, 4700-4701AHCD Part 3 thru Part 6; 4766.