

**Mental Health Supportive Care Plan with Open Ended Questions (v2)**

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.

<p><b>Allergy Alert:</b> _____</p> <p>_____</p> <p><b>Medications Alert:</b> I have an allergic or bad reaction and/or severe side effects to the following medication (If possible describe the adverse medication effects): _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Please see item 8 for more details regarding medication preferences.</b></p>
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**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**

**If Yes, here is my Health Care Agent information:**

Agent Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Alternate 1 Agent Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Alternate 2 Agent Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**If No, would you like help completing an Advance Directive? \_\_\_Yes \_\_\_No**

**Please Note: For Items 3 – 6 there is a “checklist” worksheet attached that could be helpful.**

**3. For you, what things may trigger a mental health crisis? (Explain please):**

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**4. Are there early warning signs you may be headed towards a crisis?**

(Explain please): \_\_\_\_\_

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**5. Are there things that are particularly difficult for you that could make a crisis worse?**

(Explain please): \_\_\_\_\_

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**6. What helps ease your distress and give you comfort in a crisis?**

(Explain please): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 can not 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):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(Please add additional page if need be)**

**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:**

\_\_\_\_\_  
Sign Your Name Date

\_\_\_\_\_  
Print Your Name

\_\_\_\_\_  
Address City State/Zip Code

**Witness Two:**

\_\_\_\_\_  
Sign Your Name Date

\_\_\_\_\_  
Print Your Name

\_\_\_\_\_  
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 this 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](mailto: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, 4700-4701 AHCD Part 3 thru Part 6; 4766.**



**Attachment: Checklist Work Sheet.**

This checklist could be helpful when working with the Mental Health Supportive Care Plan “Open Ended Questions Version” items 3 – 6. Examples are given of what some people have reported. This work sheet could serve as a discussion guide for talking things over and clarifying personal wishes. (Excerpt from MHSCP Checklist Version)

**3. Some things that could trigger a mental health crisis might include:**

- 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.

**4. Early warning signs a person may be heading towards a mental health crisis might include:**

- mounting & escalating anxiety     sleep problems/insomnia     guilt and shame
- off medications     depression     paranoia     suicidal thoughts     social isolation
- overeating or undereating     self-harm     loss of hope and giving up
- hearing voices     hard time communicating     can't stop crying     agitation
- having hallucinations     delusional thinking     using alcohol or other drugs

**5. Things that are particularly difficult for me that could make a crisis worse might 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 assumption 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     take downs
- not being listened to     not being informed about my care     increase in physical symptoms

**6. Things that help ease distress and give comfort might include:**

- feeling cared about and valued with my beliefs, values and preferences respected
- 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. . .