

Advance Directive for Mental Health Treatment  
(MODEL FORMAT)

I, \_\_\_\_\_, being a person with capacity to make mental health treatment decisions, willfully and voluntarily make known my wishes about mental health treatment by my instructions to others through this advance directive for mental health treatment, or by my appointment of an agent, or both, as authorized by the New Mexico Mental Health Treatment Decisions Act. I understand this advance directive becomes effective when one qualified mental health professional and one mental health treatment provider determine that I lack the capacity to make my own mental health treatment decisions.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if it is determined that I do not have capacity unless I successfully challenge that determination.

I understand there some instances where my provider may not have to follow my directives, specifically, if the treatment I directed 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 laws.

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

**INSTRUCTIONS FOR MENTAL HEALTH TREATMENT**

If it has been determined that I lack the capacity to make my own mental health care treatment decisions and that mental health treatment is necessary, I direct that I be provided the mental health treatment I have indicated below by my signature. I understand that "mental health treatment" means services provided to prevent or reduce the symptoms of or aid in the recovery from mental illness or emotional disturbance, including but not limited to treatment with medication, counseling, rehabilitation services, electroconvulsive treatment, or evaluation for admission to a facility for care or treatment of persons with mental illness, if required.

**I. My instructions about treatment, facilities and providers**

I would like the following healthcare provider(s) to be consulted about my treatment decisions:

Provider: \_\_\_\_\_ Contact Information \_\_\_\_\_

Provider: \_\_\_\_\_ Contact Information \_\_\_\_\_

I do not wish to be treated by Dr. \_\_\_\_\_

Other Instructions: \_\_\_\_\_

**II. My instructions about other health care providers**

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

Name/Profession: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Name/Profession: \_\_\_\_\_

Contact Information: \_\_\_\_\_

**III. My instructions about medications for mental health treatment**

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 have allergies to, or severe side effects from, the following: \_\_\_\_\_

Other instructions about medications: \_\_\_\_\_

**IV. My Instructions about alternatives to hospitalization and hospitalization**

The following may help me avoid a hospitalization:

\_\_\_\_\_

\_\_\_\_\_

If hospitalization is recommended I wish to be treated at: \_\_\_\_\_

I generally react to being hospitalized as follows:

\_\_\_\_\_

**V. My Instructions about the use of seclusion or restraint**

If a mental health treatment provider is considering whether or not to use seclusion or restraint on me, I would like the following to be tried before the use of seclusion or restraint is considered (circle choices):

“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):

\_\_\_\_\_

**VI. My instructions about electroconvulsive therapy (ECT)**

I do **not** consent, nor authorize my agent to consent to ECT. \_\_\_\_\_ (Initials)

I **consent** and authorize my agent to consent to ECT. \_\_\_\_\_ (Initials)

I consent, and authorize my agent to consent, to ECT **only** under the following conditions:

\_\_\_\_\_;

\_\_\_\_\_ (Signature)

**VII. Instructions about visitors**

If I have been admitted to a mental health treatment facility, the following people may visit me there.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

**VIII. Additional instructions:**

Other instructions about my mental health care:

I direct the following concerning the care of my minor children:

I direct the following concerning the care of my residence:

I direct the following concerning the care of my pets:

**APPOINTMENT OF AGENT**

Should it be determined that I lack capacity to make mental health treatment decisions, I direct my health care professionals to follow the instructions of my agent. I appoint:

Name: \_\_\_\_\_

Address/Telephone \_\_\_\_\_

to make decisions regarding my mental health treatment.

(Optional) 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 in the alternative:

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 or she believes is in my best interest.

**ACCEPTANCE OF APPOINTMENT**

I accept this appointment and agree to serve as the agent to make mental health treatment decisions for \_\_\_\_\_ while he/she does not have capacity to make mental health treatment decisions and that I have a duty to make decisions consistent with the desires expressed

in this appointment. \_\_\_\_\_ (signature)

**(Optional)** I accept this appointment as an *alternate* and agree to serve as the agent to make mental health treatment decisions for \_\_\_\_\_ while he/she does not have capacity to make mental health treatment decisions and that I have a duty to make decisions consistent with the desires expressed in this appointment. \_\_\_\_\_ (signature)

*(Note: It is OK to have an agent write an acceptance on a separate paper.)*

**SIGNATURE AND WITNESS**

I understand the importance of the advance directive for mental health treatment and I have the emotional and mental capacity to make this mental health advance directive.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Signature

County, City and State of Residence \_\_\_\_\_

This advance directive was signed in my presence:

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Address of Witness

Notary Block (OPTIONAL)

State of New Mexico    }  
                                  ss}  
County of \_\_\_\_\_    }

SUBSCRIBED AND SWORN TO before me on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by \_\_\_\_\_.

\_\_\_\_\_ my commission expires: \_\_\_\_\_  
Notary Public

I have given copies of this Advance Directive for Mental Health Treatment to:

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_