PSYCHIATRIC LIVING WILLS

A patient in a psychiatric institution is often deprived of his rights, in particular of his right to informed consent, that is to say he is deprived of his right to take decisions about his treatment, to accept or refuse a given treatment or to chose between various alternatives.

One of the arguments used by hospitals is that the patient (supposedly) lacks the ability to take decisions, because of his mental illness. Often it is the same psychiatrist who decides on the incapacity of the patient and who decides on the treatment to be administered the patient.

Any patient fearing such a situation can make a ***psychiatric living will*** at a time when his capacity cannot be put in doubt. Two major options are available :

1) ***to designate a health care agent (and, if desired, an alternate) who will take the decisions for the patient;***

2) ***to give instructions regarding treatment and care.***

The patient can chose one or the other option, or both in which case the person appointed ***health care agent*** will have to follow the instructions given by the patient. It is very important to select the health care agent carefully. The person should be an adult, may or may not be related to the patient and should have his complete trust.

Psychiatric living wills must be signed by the patient and a legal person (notary or lawyer) or two adult witnesses, other than the agent or the alternate. The patient is always free to change his mind and revoke the authority given his agent, appoint another agent or change the instructions regarding treatment and care.

Psychiatric living wills or executed copies thereof should be kept by the patient and should be given to his health care agent (if he has appointed one,) to his doctor and to the psychiatric institution where he could be committed. If the patient has appointed a health care agent, the doctor and the institution should be instructed to inform the agent at once if the patient is committed, irrespective of whether he is deemed capable or incapable of taking decisions. The agent will thus be able to take action if the patient's rights are not respected. Alternatively, if the patient has a lawyer, a trusted family member or other trusted person, they can be given copies of the psychiatric living will and instructions can be given that they should be advised if the patient is committed.

Notwithstanding the psychiatric living will, the patient has the right to make medical and other health care decisions for himself so long as he can give informed consent to the particular decision. However, it is the doctor, in the first instance at least, who will decide whether a patient has or not the capacity to take decisions. Hence the importance of having a trusted health care agent or lawyer.

Hereafter we produce a model of a psychiatric living will based on a document coming from California.

I. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. DESIGNATION OF HEALTH CARE AGENT

I, (insert your name) ..... do hereby designate and appoint :

Name .....

Address .....

.....

Phone Number : (.....) .....

as my agent to make health care decisions for me as authorized in this document.

2. GENERAL STATEMENT OF AUTHORITY GRANTED

If I become incapable of giving informed consent to health care decisions, I hereby grant to my agent full power and authority to make physical and / or mental health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any care, treatment, service or procedure, except for any limitations I set forth in this document. In making these decisions, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent.

II. STATEMENT OF DESIRES, SPECIAL PROVISIONS AND LIMITATIONS REGARDING MY MENTAL HEALTH TREATMENT AND CARE

Instructions :

This document makes known your desires regarding mental health treatment in the spaces provided below. If there are types of mental health treatment that you do or do not want to be used, you should state them in the spaces below. The more details you specify in this document, the more control over treatment you will have in the event you are found to be not legally competent to make decisions.

Your agent must make mental health care decisions that are consistent with your known desires. You can, but are not required to, state your desires regarding mental health treatment in the spaces provided below. If you want to limit in any way the authority given your agent by this document, you should state the limits in the spaces below. You can also make your desires known to your agent by discussing your desires regarding mental health treatment with your agent or by some other means. If you do not state any desires or limits, your agent will have broad powers to make mental health care decisions for you. (Except to the extent that the law limits these powers).

1. REGARDING MEDICATIONS FOR PSYCHIATRIC TREATMENT :

If during an admission or commitment to a mental health treatment or care facility, it is determined that I am not legally competent to consent to or refuse medications relating to my mental health treatment, my wishes are as follows :

(*Instruction* : Complete sections **A** and **B** and **C**. Filling out section **D** is optional.)

A. ☐ I consent/authorize my agent to consent to the administration of :

Medication name :	**N o t to exceed the following dosage :**	**O R, in such dosage (s) as determined by :**
_____	_____	Dr. _____ *(Name)*
_____	_____	_____ *(Address)*
_____	_____	_____ *(Phone)*
_____	_____	_____

--- *o r* ---

☐ As Dr. ..... deems appropriate.

B. I specificaliy **do not** consent (nor do I authorize my agent to consent) to the administration of the following medications :

.....

.....

.....

See next page

C. (*Instruction* : Check either **1** or **2**)

☐ **1.** For medications I have not listed in **A** or **B** above, I leave the decision to my agent.

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☐ **2.** For medications I have not listed in **A** or **B** above). **I <u>do not</u>** consent (nor do I authorize my agent to consent).

D. Other instructions and preferences regarding the administration of psychiatrc medications (For example, night, morning, by pill or shot) :

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2. REGARDING ELECTROCONVULSIVE THERAPY (ECT or SHOCK TREATMENT)

If during an admission or commitment to a mental health treatment facility, it is determined that I am

not legally competent to consent to or refuse electroconvulsive therapy at that time, my wishes regarding electroconvulsive therapy are as follows :
(*Instruction* : Choose either section **A** <u>or</u> **B**. Section **C** is optional.)

☐ **A.** I **<u>do not</u>** consent to the administration of electroconvulsive therapy.

☐ **B.** I consent to the administration of electroconvulsive therapy:
(Select **1** <u>or</u> **2** <u>or</u> **3**.)

☐ **1.** with the number of treatments that the attending psychiatrist deems appropriate.

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☐ **2.** with the number of treatments Dr. ..... deems appropriate.

Address : .....

Telephone : (.....) .....

--- o r ---

☐ **3.** for no more than the following number of treatments : .....

see next page

C. Other instructions and wishes regarding the administration of electroconvulsive therapy :
.....
.....

3. REGARDING EMERGENCY USE OF SECLUSION AND/OR RESTRAINTS

If during an admission or commitment to a mental health treatment or care facility it is determined that I am engaging in behavior which would require an emergency intervention (e.g., seclusion and/or physical or chemical restraint), my wishes regarding which form of emergency interventions to be used are as follows. I prefer the following order :

(*instructions* : Number according to preference : **1, 2, 3, 4**)

_____ seclusion alone
_____ seclusion and physical restraint
_____ medication by injection
_____ oral medication
other : _____

4. REGARDING OTHER FORMS OF MENTAL HEALTH TREATMENT

I consent/authorize my agent to consent to the following other types of mental health care or treatment (e.g., outpatient therapy, group therapy, family therapy, day treatment) :
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My wishes regarding placement upon discharge from an inpatient facility are as follows:

(*Instruction* : Name particular programs facilities or types of programs you **do** or **do n o t** prefer (e.g. Smith's Board & Care Home, Community Halfway house, crisis alternative programs.)
.....
.....
.....

Other limitations regarding mental health treatment :

(*Instruction* : For example, I prefer Jones Hospital for inpatient treatment.)
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.....

(See next page)

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

III. OTHER APPOINTMENTS AND LIMITATIONS

1. DESIGNATION OF ALTERNATE (HEALTH CARE) AGENT (optional)

(You are **not** required to designate any alternate agents but you may do so. Any alternate agent you state will be able to make the same health care decisions as the agent designated on page 180 of this document if he or she is unable or unwilling to act as your agent.)

If the person designated as my agent on page **180** is unable or unwilling to make health care decisions for me or is disqualified by law from so doing, then I designate the following persons to serve as my agent in making health care decisions for me as authorized. Such persons are to serve in the following order:

a. First Alternate Agent :

Name : .....

Address : .....

Telephone Number : (.....) .....

b. Second Alternate Agent :

Name : .....

Address : .....

Telephone Number : (.....) .....

2. NOMINATION OF CONSERVATOR (GUARDIAN) OF MY PERSON (optional)

(You are not required to nominate a conservator but you may do so.) A conservator of the person may be appointed for you if a court decides that you are unable to properly provide for your personal needs for physical health, food, clothing or shelter. The court will appoint the person you pick, unless that would be contrary to your best interests. You may select a person other than your health care agent to serve as your conservator.

If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person:

Name : .....

Address : .....

Telephone Number: (.....) .....

3. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Except for any limitation I set forth in this document, my agent has the power and authority to do all of the following:

a. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

b. Authorize on my behalf any releases or other documents that may be required in order to obtain this information.

c. Consent to the disclosure of this information.

(If you want to limit the authority of your agent to receive and disclose information relating to your physical or mental health, you may state the limitations below. For example, you may limit disclosure of information to certain persons.)

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4. SIGNING DOCUMENTS, WAIVERS, AND RELEASES

Where necessary to carry out the health care decisions that my agent is authorized to make, my agent has the power and authority to execute on my behalf all of the following :

a. Documents such as a '*Refusal to Permit Treatment*' and '*Leaving Hospital Against Medical Advice.*'

b. Any necessary waiver or release from liability required by a hospital or physician.

see next page

(If you want to limit the authority of your agent to sign documents, waivers, and releases, you may state the limitations below.)

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IV. SIGNATURE / WITNESS STATEMENT

DURATION

I understand that this DURABLE POWER OF ATTORNEY FOR HEALTH CARE will exist indefinitely, unless I establish a shorter time.

[Optional] I wish to have this DURABLE POWER OF ATTORNEY FOR HEALTH CARE end on *the following date :* .....

.....

YOU MUST DATE AND SIGN THIS
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I sign my name to this Durable Power of Attorney for Health Care on

(date) ..... at (city) .....(country) .....

Signature : .....

THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS <u>EITHER</u> :

☐ **(1)** signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

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☐ **(2)** acknowledged before a notary public or lawyer according to the law of your country.

DEPRIVED of Our HUMANITY

The Case against Neuroleptic Drugs

Lars Martensson, M.D.

The Voiceless Movement
Mouvement Les Sans-Voix