

Wellness Recovery Plan, Crisis Plan and Advance Directive

Introduction

Cenpatico Behavioral Health of Arizona (Cenpatico) and your agency are offering this guide to you to help you develop your Wellness Recovery Plan, Crisis Plan and Advance Directive.

We believe that in order to achieve your recovery goals it is important to provide you the tools to have your voice listened to and heard. Your choices are important to us.

Completing the information in this guide will make sure that your voice and choices are taken into consideration to help provide you the treatment and services to help you on your recovery journey.

The information contained in this guide will help you make your wishes known about what helps and what doesn't help when it comes to your behavioral health treatment.

Your recovery needs should be discussed with your clinical team and people that you trust who have your best interest at heart. This guide will help provide the opportunity to have that discussion with your clinical team and people you trust.

The first few pages of the guide ask questions about: What you are feeling when you are well, when you are not at your best, when you may need a little help.

If you find yourself going into a crisis the information in this guide can help identify early warning signs and triggers and help reduce or eliminate the symptoms by using some of the coping skills identified in your plan.

Should you happen to go into a crisis this plan can be used to let the different treatment professionals, hospital staff, provider staff and your support people know what your wishes are if you are not able to communicate those wishes to your team.

Although this guide provides you some tools to have your voice and choice heard, you are free to use these tools or any alternative tools of your choice.

The last page of this guide gives you the option to make this plan a Mental Health Care Advance Directive. If you need more information on Wellness Recovery Plans, Crisis Plans or Advance Directives please contact your Case Manager, Clinical Liaison or Peer Support Specialist. If you have further questions please feel free to contact Cenpatico's Consumer Advisor at 1-866-495-6738.

Wellness Recovery Plan, Crisis Plan and Advance Directive

Name: _____ Date: _____

Updated: _____

Things I enjoy doing

What I'm like when I'm feeling good

Things I enjoy doing everyday

Things I can do each day to relieve stress and feel better

Things that may trigger my symptoms

Things I can do to help me control my symptoms

Signs that things are not going well for me or my family

Things I can do to help me stop feeling bad

When I am feeling much worse

Things to help me feel better when I am feeling much worse

Crisis Plan (A crisis plan may need to be put into action way before the person is no longer able to make decisions and should be developed with the idea that the person and/or other individuals will intervene before the situation gets to this point)

I need help when I: (The following symptoms indicate that I am no longer able to make decisions for myself, that I am no longer able to be responsible for myself or to make appropriate decisions.)

People that may help me during this time (Supporters)

Name _____ **Relationship** _____

Address _____

Phone Number _____

Area of expertise or specific thing I would like them to take care of

Name _____ **Relationship** _____

Address _____

Phone Number _____

Area of expertise or specific thing I would like them to take care of

Name _____ **Relationship** _____

Address _____

Phone Number _____

Area of expertise or specific task I would like them to take care of

I do not want the following people involved in any way in my care or treatment.

Name	Why I do not want them involved (optional)
_____	_____
_____	_____
_____	_____

Also, list those people you want your supporters to notify if you are in a crisis, such as your employer or family members--along with what to tell each of them.

People to Notify	
Please notify	Tell them
_____	_____
_____	_____
_____	_____
_____	_____

How I want disputes between my supporters settled

Medical Information / Medications / Supplements / Health Care Preparations

Physician

Name _____ **Phone number** _____

Psychiatrist

Name _____ **Phone number** _____

Other Health Care Providers

Name _____ **Phone number** _____

Area of expertise

Name _____ **Phone number** _____

Area of expertise

Name _____ **Phone number** _____

Area of expertise

Pharmacy _____ **Phone number** _____

Known Allergies

Insurance numbers and other insurance information

Medications that I am presently taking

Name

Dosage _____

Purpose

Name

Dosage _____

Purpose

Name

Dosage _____

Purpose

Medications and/or other treatments to be used if needed

Name _____ **Dosage** _____

When to use

Name _____ **Dosage** _____

When to use

Name _____ **Dosage** _____

When to use

Type of Treatment / Supportive Service

When to use

Type of Treatment / Supportive Service

When to use

**** Medications / Supportive Services / Treatments to avoid**

Name _____

Should be avoided because

Name _____

Should be avoided because

Name _____

Should be avoided because

****take special note**

Treatments, Supportive Services and Complementary Therapies

Name _____

When and how to arrange for use

Name _____

When and how to arrange for use

Home/Community Care/Respite Center

If possible, help me use the following care plan:

Hospital or other Treatment Facilities

If I need hospitalization or treatment in a treatment facility, I prefer the following facilities in order of preference

Name _____

Contact Person _____

Phone Number _____

I prefer this facility because _____

Name _____

Contact Person _____

Phone Number _____

I prefer this facility because _____

Avoid using the following hospital or treatment facilities

Name	Reason to avoid using
_____	_____
_____	_____
_____	_____
_____	_____

Help From Others

Please do the following things that would help reduce my symptoms, make me more comfortable and keep me safe.

I need (name the person) _____ **to (task)**

I need (name the person) _____ **to (task)**

I need (name the person) _____ **to (task)**

I need (name the person) _____ **to (task)**

Do not do the following. It won't help and it may even make things worse.

When My Supporters No Longer Need to Use This Plan

The following signs, lack of symptoms or actions indicate that my supporters no longer need to use this plan.

I developed this plan on (date) _____ with the help of (name of person and relationship to me) _____

Any plan with a more recent date supersedes this one.

Print Name: _____

Signature: _____

Date: _____

What is an Advance Directive?

An Advance Directive is a written document, such as Durable Mental Health Care Power of Attorney, in which you give instructions about your mental health care, what you want done or not done, if you can't speak for yourself.

What are Advance Directives for health and mental health care?

These are documents you create that appoint someone else to make health care or mental health care decisions in the event you become incapacitated or incapable of making treatment decisions.

What do I do with my Advance Directive?

When you create an Advance Directive, you remain in control of your health care decisions as long as you are able to communicate your wishes. If you are no longer able to make decisions for yourself, doctors and other health care providers are obligated to follow your wishes outlined in your Advance Directive according to the laws in the State of Arizona.

While it is optional, if you would like to make the instructions in this document an Advance Directive please complete the information below and complete an Arizona Durable Mental Healthcare Power of Attorney form. This form is available at http://www.azag.gov/life_care/POA_MentalHealthCare.pdf

OPTIONAL

Signature _____ Date _____
(Only sign this document if you are making this document your Advance Directive for Mental Health)

Witness _____ Date _____

Witness _____ Date _____

Durable Power of Attorney Agent

Name: _____

Address: _____

Phone Number: _____

Substitute for Durable Power of Attorney Agent

Name: _____

Address: _____

Phone Number: _____

NOTE: While State Law does not require an attorney to sign your Advance Directive it is Cenpatico Behavioral Health of Arizona's recommendation that you have a trusted advocate or attorney look over this document.