My *Declaration for Mental Health Treatment*
(My Psychiatric Advance Directive)

Purpose and Instructions:

The purpose of this ***Declaration for Mental Health Treatment*** document is to empower you to make your treatment preferences known. It can help to improve communication between you and your doctor, you and other staff, and you and your family members involved in your recovery. Having a psychiatric advance directive may even shorten a hospital stay or help you avoid one.

The ***Declaration for Mental Health Treatment*** was created by South Carolina Department of Mental Health patients and staff. The document should be respected by private providers inside and outside of the state of South Carolina.

Instructions:

A ***Declaration for Mental Health Treatment*** can be presented by your or by an agent you appoint. An agent is a friend, family member or someone else you trust who makes sure the hospital has a copy of your ***Declaration for Mental Health Treatment*** if you did not take one with you. The agent can also help to make decisions about your treatment if it is not covered in the ***Declaration for Mental Health Treatment*** or if some part of the ***Declaration for Mental Health Treatment*** cannot be followed for good reasons.

Five things to remember:

1. S.C. does not recognize Statements of Desires without appointment of an agent/surrogate under a Health Care Power of Attorney. Forms for a Health Care Power of Attorney can be found in the South Carolina Code of Laws at Title 62 – South Carolina Probate Code, Article 5, SECTION 62-5-504.

2. Your case manager or other mental health worker cannot be your agent.

3. It is important that you understand that in an emergency, a doctor can do something different from what you have stated in your Declaration for Mental Health Treatment, but the doctor must go through certain steps to do this.

4. It is up to you or your agent to make sure that the hospital has a copy of your ***Declaration for Mental Health Treatment***. You may want to have a copy placed in your outpatient record so that outpatient staff are aware of what hospital or crisis stabilization approaches you would prefer, if you are not able to express your own choices at the time.

STATEMENT OF MY INTENT

I, (your name)_____, being able to make my own choices, willfully and voluntarily execute this ***Declaration for Mental Health Treatment*** (Psychiatric Advance Directive) to be sure that if I am unable or considered unable to make my own decisions because of mental or physical illness or if I am not communicating clearly, my choices about my mental health care will be carried out, even if I cannot make informed decisions for myself at that time.

If a guardian or someone else is chosen by a court to make decisions for me, I intend this document to come before all other instructions.

With this document, I intend to create a ***Declaration for Mental Health Treatment*** for health care as authorized by state law, the U.S. Constitution and the Federal Patient Self-Determination Act of 1990 (P.L. 101-508) to indicate my wishes regarding mental health treatment.

I am stating what I want to happen regarding my mental health treatment. If any of this ***Declaration for Mental Health Treatment*** (psychiatric advance directive) is not considered valid under state law, I ask that it be considered a statement of what kind of treatment I want. I intend that it will be given the greatest legal weight and respect possible by staff members of a hospital.

I understand that this document will become active if I am unable to communicate clearly or if I am determined not to be able to make my own choices at that time. It will be in effect only so long as I am unable to communicate clearly or if I am not able to make my own choices.

What I have stated in this document should be honored with or without an agent involved. If I chose an agent, and that person dies or withdraws at the time this document is in effect, this document should still be honored.

This document will be binding on anyone named as my agent or named to make decisions for me.

If I have left blanks in this document (left out certain sections), that will not make the document invalid in any way, because I intend that all sections I have filled out be followed.

If I have left a section blank, my agent, if I have appointed one, will make a decision that is what he or she thinks I would make, if I were able to do so.

If any section of this ***Declaration for Mental Health Treatment*** isn't valid or effective under relevant law, all other parts will be considered valid and effective.

I want each part of this document to stand alone.

I understand that in an emergency situation, a doctor can decide to do something different from what is in this document, but that the doctor must go through a certain procedure to justify doing this.

I want this ***Declaration for Mental Health Treatment*** to come before any and all other documents I have made in the past related to my care and treatment as a mental health patient, if they are not consistent with this document.

This is my ***Declaration for Mental Health Treatment***. It is also known as a psychiatric advance directive.

_____
(Please print your name)

_____
(Please sign your name)

_____
(Today's date)

My *Declaration for Mental Health Treatment*

(Psychiatric Advance Directive)
Summary

If I am in crisis or in case of a psychiatric emergency:

1. My case manager's name is: _____

2. Doctors I want notified are:
A. _____
B. _____
C. _____

3. Persons I want notified are:
A. _____
B. _____
C. _____

4. ___I have completed a Psychiatric Advanced Directive and/or a WRAP Plan and wish treatment providers follow the instruction I have laid down in it to the fullest extent possible.

5. ___I have appointed an agent to make decisions for me in the event I am not capable of communicating my preferences for treatment at this time. That person is:
Agents Name: _____
Address:_____
City:_____State:_____Zip:_____
Day Phone:_____Night Phone:_____Cell Phone_____

Agent's Acceptance:
I hereby accept the appointment as agent for (your name) _____
Agent's Signature: _____

These Are My Wishes, Instructions, Special Provisions and Limitations in My Mental Health Treatment and Care (_____your name)

I. My choice of Treatment Facility or other alternative to hospitalization if it is medically necessary for me to have 24-hour care for my safety and well being.

A. _____If I am to go into a hospital for 24-hour care, I choose to go to the following hospitals:

1. _____
2. _____
3. _____

B._____If my condition requires 24 hour psychiatric care but it is not necessary to be in a hospital, I choose to have this care in programs and facilities that are considered alternatives to psychiatric hospitals listed below:

1. _____
2. _____
3. _____

C. _____I choose to receive crisis stabilization at the following programs/facilities:

1. _____
2. _____
3. _____

D._____I do not want to be committed to the following hospitals or programs/facilities for the following reasons (optional) if I need psychiatric care.

Facility's Name and Reason *(optional)*:

1. _____
2. _____

II. My Choices Regarding Emergency Interventions:

If I engage in behavior that requires an emergency intervention (such as seclusion, restraint or medications), I choose the interventions in the order listed below.

Most preferred is 1, next is 2 and so on until there is a number by each option

_____seclusion
_____physical restraints
_____seclusion and physical restraints
_____medication by injection
_____medication in pill form
_____liquid medication
_____other_____

Put your initials by this section if you agree; <u>if you don't agree, leave it blank</u>.

_____If after considering the choices I have listed above, the doctor attending me decides to use medication to tranquilize me quickly (rapid tranquilization) in an emergency situation I expect the doctor to use medication that reflects the choices I have stated in this Declaration. The choices I agree to concerning emergency medications do not give consent for using these medications for non-emergency treatment.

III. My Choices about Medication(s):

A. I prefer medication given to me: □ Orally □ Pill □ Liquid □ Injection

B. The following medications have been the most helpful to me in the past and I would consent to taking them, if appropriate:

1. _____
2. _____
3. _____

C. If I am hospitalized and am not considered able to consent or refuse medications related to my mental health treatment, my wishes are as follows:

(I) _____I consent to and give permission to my agent to consent to the use of the following medication(s):

1. _____
2. _____
3. _____

(II) _____I specifically do not consent to and I do not give permission for my agent to consent to me taking the following medications, no matter what their brand name or generic equivalent:

1. _____
2. _____
3. _____

(III)_____I consent to the medications that are considered appropriate by Dr._____whose address and phone number is:
Address_____
City_____State:_Zip:_____
Phone Number:_____

D. I am concerned about the side effects of medications. I wish to be told about the possible medication side effects if any of these side effects listed below are possible or to be told how these side effects can be managed.

_____tardive dyskinesia
_____motor restlessness
_____blurred vision
_____sleep problems
_____tremors
_____neuroleptic malignant syndrome
_____dizziness

_____loss of sensation
_____seizure
_____cognitive (thinking) problems
_____aggressiveness
_____nausea/vomiting/diarrhea
_____muscle/skeletal rigidity
_____mood swings

_____sexual dysfunction

_____other

F. I am allergic to the following medications: (medication and reaction if known)

1. _____
2. _____
3. _____

IV. My Choices about Personal Interventions:

A. Others will know when I am having a hard/difficult time or when I am upset if I am;

_____

_____

B. Approaches that I and others can use to help me when I'm having a hard time or when I'm expressing anger inappropriately: **(Check all that apply)**

- ☐ voluntary time out in my room
- ☐ voluntary time out in a quiet room
- ☐ sitting by staff
- ☐ talking with a peer
- ☐ talking with staff
- ☐ having my hand held
- ☐ going for a walk
- ☐ punching a pillow
- ☐ writing in a journal
- ☐ lying down
- ☐ listening to music
- ☐ reading
- ☐ watching TV
- ☐ pacing the halls
- ☐ calling a friend
- ☐ talking with my therapist
- ☐ pounding some clay
- ☐ exercising
- ☐ deep breathing exercises
- ☐ taking a shower
- ☐ praying
- ☐ meditation
- ☐ singing
- ☐ getting a hug
- ☐ yelling or screaming
- ☐ being silent
- being outside
- ☐ calling crisis hotline
- ☐ being given an opportunity to be heard and validated without being offered advice/suggestions
- ☐ talking to: (name: phone #:)
- ☐ recreational activities:
- ☐ other
- ☐ other

C. Special Wishes about Touch/Body Space **(check all that apply)**

____I do not wish to be touched.
____I wish to be asked permission before being touched.
____I wish to be told the reason why I am being touched.
____I wish special attention be given to allowing me extra personal body space.
____I do not need special attention given to my body space.
____Other:_____

V. My Choices Regarding Release of Information about My Health

If I am hospitalized, I voluntarily give permission for the following information about me to be given by the hospital where I am currently admitted to the people listed below.

I realize that I may also have to sign a release of information for the hospital, but this Declaration for Mental Health Treatment should be followed concerning the limits of information provided to each person listed. The information can be given in writing or verbally.

1. Name of Individual: _____
Address: _____
City: _____ State: _____ Zip: _____
Day Phone: _____ Night Phone: _____
Type of information to be released:
___Diagnosis ___Payment Status
___Discharge Plan ___Treatment Plan
___Medications

___Other _____

2. Name of Individual: _____
Address: _____
City: _____ State: _____ Zip: _____
Day Phone: _____ Night Phone: _____
Type of information to be released:
___Diagnosis Payment Status
___Discharge Plan ___Treatment Plan
___Medications

___Other _____

3. Name of Individual: _____
Address: _____
City: _____ State: _____ Zip: _____
Day Phone: _____ Night Phone: _____
Type of information to be released:
___Diagnosis Payment Status
___Discharge Plan ___Treatment Plan
___Medications

___Other _____

VI. **My Choices about Whether Or Not I Can Cancel This *Declaration for Mental Health Treatment***

Put your initials by the section that you wish to apply.

_____My wish is that **I can cancel** this Declaration at any time.

_____My wish is that **I cannot cancel** this Declaration if I am considered unable to make informed decisions due to psychiatric illness. I choose this to make sure that my well thought out decisions that I made while I was able will remain in effect.

____In spite of the above, I want my agent to ask me about my choices before making decisions about my mental health care.

SIGNATURES *(A notary is not required, but the space below is for use by a notary, if you choose to use one.)*

I intend that my signature here indicates that I understand the reasons for this document and its effects._____(Sign your Name Here)

WITNESSES (Two Required)

This ***Declaration of Mental Health Treatment*** of *(your name)*_____is witnessed by us at his/her request. At the time that the person above created this *Declaration*, he/she was, to the best of our knowledge and belief, legally competent and not under any constraint or undue influence. We declare that neither of us is a physician, this person's physician or an employee of this person's physician, an employee of any hospital, mental health center or program, or residential care facility in which this person resides, an agent or alternate under this advance directive, or a beneficiary or creditor of the estate of this person. Dated at:_____(County/State) On_____, 2_____

Witnesses' Signatures:

Name of Witness 1 (printed) _____
Home address of Witness 1 _____
City, State, Zip Code of Witness 1 _____

Name of Witness 2 (printed) _____
Home address of Witness 2 _____
City, State, Zip Code of Witness 2 _____

Notary:

State of_____County of_____This document was subscribed and sworn to before me by the Declarant, _____
And (names of witnesses) [1]_____[2]_____
as the fully voluntary act and deed of the Declarant on (date) _____
My commission expires: (date) _____
Notary Public:_____

IX. APPOINTMENT OF AN AGENT FOR MY MENTAL HEALTH CARE

1. Place your initials after one choice below.

_____I wish to appoint an agent._____I do not wish to appoint an agent.

2. Complete this section only if appointing an agent.

I, *(your name)*_____, being an able person, appoint a health care agent. My agent can make certain decisions for me about my mental health care when I am declared unable to do so. I intend for his/her decision to be made in agreement with my expressed wishes as written in this *Declaration for Mental Health Treatment*. If I have left any section blank in this document, I give permission for my agent to make a decision based on what he/she thinks I would want if I were unable to make a decision.

1st Choice of Mental Health Care Agent

I hereby choose the following person to be my agent to make decisions about my mental health care for me as approved in this *Declaration for Mental Health Treatment*. My agent should be told immediately if I am admitted to a psychiatric facility.

Agents Name: _____

Address:_____

City:_____State:_____Zip:_____

Day Phone:_____Night Phone: _____

Agent's Acceptance I hereby accept the appointment as agent for (your name) _____Agent's Signature: _____

C. Authority Granted to my Agent

If you agree with a statement, put your initials by it. If you don't, leave it blank.

1,_____If it is decided that I am not able to consent to mental health treatment; I hereby give my agent full power and authority to be the one to make mental health choices for me. This includes the right to agree to, refuse to agree to or to withdraw agreement for any type of mental health care, treatment, procedure or service that agrees with my instructions in my ***Declaration for Mental Health Treatment***. If I did not express a choice in this document, I give permission for my agent to make the decision he/she feels is what I would make if I were able to do so.

2._____I have named an agent, but I want to be able to discharge or change my agent if my agent helps start or extend any period of psychiatric treatment that is against my will. I will be allowed to discharge or change my agent, even if I am not legally competent. Even if I discharge or change my agent, the rest of this ***Declaration for Mental Health Treatment*** will stay in effect.

_____(Please print your name)

_____(Please sign your name)

_____(Date)