My Declaration for Mental Health Treatment

This is My Psychiatric Advance Directive.

Your Name: _______________________

Today’s Date: _____________________
Acknowledgements

The purpose of this Declaration for Mental Health Treatment document is to empower people to make their treatment preferences known.

This document is also known as a psychiatric advance directive.

You will hopefully find that having a psychiatric advance directive (PAD) improves communication between you and your physician. It may also help improve communication between you and other staff and/or family involved in your care. Having a psychiatric advance directive may even shorten a hospital stay or help you avoid one all together.

The Declaration for Mental Health Treatment format was created by consumers of mental health services. The combined wisdom of the participants in this process represents more than 750 years of recovery experience!

The Declaration for Mental Health Treatment format was created for people who receive services from centers and hospitals affiliated with the South Carolina Department of Mental Health. The document should, however, be respected by private providers inside and outside of the state of South Carolina.

The process of creating the Declaration for Mental Health Treatment began in the late fall of 2002 and finished in the spring of 2004. It involved many mental health stakeholders.

- CORE
- The Mental Health Association in South Carolina
- SC Share
- NAMI of South Carolina
- PAIMI Council
- Consumer Advisory Boards at local mental health centers
- Consumer Affairs Coordinators at local mental health centers and hospitals
- SCDMH Consumer-to-Consumer Evaluation Team
- SCDMH Office of Consumer Affairs
- Members of SCDMH Senior Management
The chief editor of the Declaration for Mental Health Treatment format was Sharan Ramsauer, Ph.D.

Dr. Ramsauer is a self-identified consumer employee of the Mental Health Association in South Carolina (MHASC) and a well-known public speaker, educator and support group leader. Dr. Ramsauer reviewed several psychiatric advance directives from other states before compiling a version of what a PAD needed to contain to be considered recovery-oriented and person-centered. After over a year of discussion meetings in Columbia with members of the Consumer Affairs Council and with her own organization’s members (CORE), a final draft of the Declaration for Mental Health Treatment format was approved for use on January 21, 2004 by the South Carolina Department of Mental Health and its Clinical Care Coordination Committee, headed by Dr. Ron Prier, Medical Director.

For a copy of this document and/or additional examples of Psychiatric Advance Directives, please go to the SCDMH Web site at www.mentalhealth-recovery.com under the heading of Consumer Resources.

On behalf of Dr. Ramsauer, CORE, the SCDMH Consumer Affairs Council, and the SCDMH Consumer Advisory Board, thank you for filling out a Declaration for Mental Health Treatment.

We sincerely believe it will be helpful to you in your recovery.

Office of Consumer Affairs
South Carolina Department of Mental Health
2414 Bull Street, P.O. Box 485
Columbia, SC 29205

March 22, 2004
This document is my Declaration for Mental Health Treatment. It is also known as a psychiatric advance directive.

This Declaration for Mental Health Treatment tells doctors and staff in hospitals and in other health care settings what works best for me and what I prefer in treatment, including which hospital I might prefer to be in if I need to be hospitalized (page 10). This information can be very helpful for staff and can protect me from treatments that have been bad for me or that I don’t like or want (page 12 and page 13).

Another reason for filling out this Declaration for Mental Health Treatment is that it helps me think about what kinds of things are signs that I need help and what might help before I reach a point where I need to go into a hospital (page 14). This could help me stay out of the hospital altogether. It also helps me think through what might help me if I am experiencing difficulties.

In South Carolina, to use a Declaration for Mental Health Treatment, I simply present my Declaration on my own to a staff person, or I may appoint an agent, if I chose to do so. An agent is a friend, family member or someone else I trust who makes sure the hospital has a copy of my Declaration for Mental Health Treatment if I did not take one with me. The agent can also make decisions about my treatment if 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. My case manager or any other mental health worker cannot be my agent.

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

It is up to me or my agent to make sure that the hospital has a copy of my Declaration for Mental Health Treatment. I may want to have a copy placed in my outpatient or community mental health center record so that outpatient staff are aware of what hospital or crisis stabilization approaches I would prefer, if I am not able to express my own choices at the time.
STATEMENT OF MY INTENT

I, (your name)__________________________________________, being able to make my own choices, willfully and voluntarily make out this Declaration for Mental Health Treatment (psychiatric advance directive) to be sure that if I am 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 make a Declaration for Mental Health Treatment (psychiatric advance directive) for health care according to state law if I have an agent, the U.S. Constitution and the Federal Patient Self-Determination Act of 1990 (P.L. 101-508).

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* (psychiatric advance directive) isn’t valid or effective under relevant law, all other parts will be considered valid and effective.

I want for 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 for 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)
Important Notice

Your *Declaration for Mental Health Treatment* can also serve as an *Addendum* to the South Carolina Statutory Form (Code of Laws Section 62-5-504) when attached to a *Health Care Power of Attorney* under Section E.

Your document may be more legally binding if attached to a *Health Care Power of Attorney*. However, all employees of the South Carolina Department of Health are expected to respect this document, as a statement of your personal wishes and preferences while in their care, regardless of whether or not it is attached to a *Health Care Power of Attorney*.

For a copy of the South Carolina Statutory Form called *Health Care Power of Attorney*, go to the SCDMH Web Site at [www.mentalhealth-recovery.com](http://www.mentalhealth-recovery.com) under Consumer Resources, then to Psychiatric Advance Directives.
Appointment of An Agent for My Mental Health Care

1. Place your initials after one choice below.
   
   _____ I do not wish to appoint an agent.
   _____ I 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 able to make a decision.

A. Choice of Mental Health Care Agent

1. 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.
   
   Name:______________________________________________________
   Address:____________________________________________________
   City:__________________________State:_______Zip:______________
   Day Phone:___________________Night Phone:____________________

2. Agent’s Acceptance
   I hereby accept the appointment as agent for
   (your name)____________________________________________________
   Agent’s Signature:________________________________________________

B. Choice of Alternate Health Care Agent

1. If the person I have named above isn’t able to serve as my agent, I hereby choose the person below as my agent and want them immediately notified.
   
   Name:______________________________________________________
   Address:____________________________________________________
   City:___________________________State:_______Zip:_____________
   Day Phone:____________________Night Phone:___________________

2. Agent’s Acceptance:
   I hereby accept the appointment as alternate agent for
   (your name)____________________________________________________
   Alternate 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)

___________________________
(Today’s date)
These Are My Wishes, Instructions, Special Provisions and Limitations in My Mental Health Treatment and Care

___________________________________________________
(print your name here)

IMPORTANT: If you want a section to apply, put your initials or a check-mark by it. If you don’t want it to apply, leave blank or write in “NA” (not applicable) across the section.

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 my psychiatric condition requires 24 hour care and I don’t have physical conditions that need immediate access to emergency medical care, I choose to have this care in programs and facilities that are considered alternatives to psychiatric hospitals listed below:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

B. _____ I choose to receive crisis stabilization at the following programs/facilities:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

C. _____ If I am to go into a hospital for 24-hour care, I choose to go to the following hospitals:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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: __________________________________________________________
Reason (optional): _________________________________________________________

Facility’s Name: __________________________________________________________
Reason (optional): _________________________________________________________

Facility’s Name: __________________________________________________________
Reason (optional): _________________________________________________________
These Are My Choices Regarding Emergency Interventions

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

Rate the intervention you prefer most as 1 and the next preferred as 2 and so on until there is a number by each option. If you prefer something not listed, put it by “other” and give it a number.

_____ seclusion
_____ physical restraints
_____ seclusion and physical restraints (combined)
_____ medication by injection
_____ medication in pill form
_____ liquid medication
_____ other ______________________

Reasons for my choices: (optional)___________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Put your initials by this section if you agree; if you don’t agree, leave it blank.

If the doctor attending me decides to use medication to tranquilize me quickly (rapid tranquilization) in an emergency situation after considering the choices I have listed above, 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.

These Are My Choices About Medication

A. I am allergic to the following medications:
Medication                                           Type of Allergy or Sensitivity if Known
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

B. I prefer medication given to me:

☐ Orally     ☐ Pill     ☐ Liquid     ☐ Injection
C. Psychotropic Medications

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.

(Check all that apply)

_____ tardive dyskinesia  _____ tremors
_____ loss of sensation  _____ nausea/vomiting/diarrhea
_____ motor restlessness  _____ neuroleptic malignant syndrome
_____ seizure  _____ muscle/skeletal rigidity
_____ blurred vision  _____ dizziness
_____ cognitive (thinking) problems  _____ mood swings
_____ sleep problems  _____ sexual dysfunction
_____ aggressiveness  _____ other
______ other
________________________________________________________________________
________________________________________________________________________

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

Medications:________________________________________________________________
________________________________________________________________________

E. 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 consent to and give permission to my agent to consent to the use of:

Medication Name:_________________________________________________________
Medication Name:_________________________________________________________
Medication Name:_________________________________________________________
Medication Name:_________________________________________________________
Medication Name:_________________________________________________________

_____ I consent to the medications that are considered appropriate by
Dr. ______________________, whose address and phone number are:

Address:________________________________________________________________
City:________________________ State:_________ Zip:___________________________
Phone Number:________________________________________________________________
I specifically do not consent 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:

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Reason for Refusal</th>
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</thead>
<tbody>
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</tbody>
</table>

Additional information about psychiatric medications:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

These Are My Choices About Electroconvulsive Therapy

If it is determined that I am not able to give consent or I refuse to consent to electroconvulsive therapy (ECT), my wishes regarding electroconvulsive therapy are as follows:

- I do not consent to the use of electroconvulsive therapy.
- I consent, and authorize my agent to consent, to the use of electroconvulsive therapy, but only:
  - with the number of treatments that the attending psychiatrist determines to be appropriate.

OR

- with the number of treatments that Dr. ____________________ determines to be appropriate. Phone number and address of doctor:
  
  Address:________________________________________________________
  City:_______________________________State:____________Zip:__________
  Phone Number:_____________________________________________________

OR

- for no more than the following number of ECT treatments:_____________

- Other instructions and wishes about use of electroconvulsive therapy:
These Are My Choices About Personal Interventions

A. How can others know when I am having a hard/difficult time or when I am upset?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

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 with:___________________________________________________________
address:______________________________________________________________
day phone:______________________night phone:____________________________
☐ recreational activities:____________________________________________________
☐ other_________________________________________________________________
☐ 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:_______________________________________________________________
These Are 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:**

<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Phone:</td>
<td>Night Phone:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type of information to be released:

- [ ] Diagnosis
- [ ] Medications
- [ ] Treatment Plan
- [ ] Discharge Plan
- [ ] Payment Status
- [ ] Progress/Status
- [ ] Other

**2. Name of Individual:**

<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Phone:</td>
<td>Night Phone:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type of information to be released:

- [ ] Diagnosis
- [ ] Medications
- [ ] Treatment Plan
- [ ] Discharge Plan
- [ ] Payment Status
- [ ] Progress/Status
- [ ] Other

**3. Name of Individual:**

<table>
<thead>
<tr>
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<th>City:</th>
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<th>Zip:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Phone:</td>
<td>Night Phone:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type of information to be released:

- [ ] Diagnosis
- [ ] Medications
- [ ] Treatment Plan
- [ ] Discharge Plan
- [ ] Payment Status
- [ ] Progress/Status
- [ ] Other
4. Name of Individual: ______________________________________________________
Address: _______________________________________________________________
City: ______________________ State: ___________ Zip: ___________
Day Phone: ________________ Night Phone: ______________________

Type of information to be released:

☐ Diagnosis       ☐ Medications       ☐ Treatment Plan
☐ Discharge Plan ☐ Payment Status       ☐ Progress/Status
☐ Other

5. Name of Individual: _____________________________________________________
Address: _______________________________________________________________
City: ______________________ State: ___________ Zip: ___________
Day Phone: ________________ Night Phone: ______________________

Type of information to be released:

☐ Diagnosis       ☐ Medications       ☐ Treatment Plan
☐ Discharge Plan ☐ Payment Status       ☐ Progress/Status
☐ Other

6. Name of Individual: _____________________________________________________
Address: _______________________________________________________________
City: ______________________ State: ___________ Zip: ___________
Day Phone: ________________ Night Phone: ______________________

Type of information to be released:

☐ Diagnosis       ☐ Medications       ☐ Treatment Plan
☐ Discharge Plan ☐ Payment Status       ☐ Progress/Status
☐ Other

7. Name of Individual: _____________________________________________________
Address: _______________________________________________________________
City: ______________________ State: ___________ Zip: ___________
Day Phone: ________________ Night Phone: ______________________

Type of information to be released:

☐ Diagnosis       ☐ Medications       ☐ Treatment Plan
☐ Discharge Plan ☐ Payment Status       ☐ Progress/Status
☐ Other
These Are My Choices About Whether Or Not I Can Cancel This Declaration for Mental Health Treatment

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

1. Canceling my Declaration.
   _____My wish is that I can cancel this Declaration at any time.

2. Canceling my Declaration if I am not considered to be able to make informed decisions.
   a. _____My wish is that I not be able to 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.

   b. _____In spite of the above, I want for my agent to ask me about my choices before making a decision about my mental health care. This is in order to take the choices I made here into account when making a decision, even if I am considered unable to make informed decisions.

My Other Instructions About Mental Health Needs

Examples: Names and telephone numbers of people who should be called regarding the care for my children, my bills, my pets and plants, etc., if I am unable to make these contacts myself.

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
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__________________________________________________________________
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__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Add additional pages as needed.
SIGNATURES
I intend that my signature here indicates that I understand the reasons for this document and its effects if granted to an Agent.

Your Signature (As Declarant)  Date

WITNESSES (Two Required)
This Declaration of Mental Health Treatment (psychiatric advance directive) 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 appointed agent or alternate under this advance psychiatric directive, a beneficiary or creditor of the estate of this person, and is not related to me by blood, marriage or adoption, either as a spouse or a lineal ancestor, nor a descendent of the person’s parents, or spouse of any of them. I am also not appointed as Health Care Agent or Successor Health Care Agent by this document.

Dated at:_________________________ (County/State)
On ____________________________, 2__________

Witnesses’ Signatures

<table>
<thead>
<tr>
<th>Signature of Witness 1</th>
<th>Signature of Witness 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Witness 1 (printed)</td>
<td>Name of Witness 2 (printed)</td>
</tr>
<tr>
<td>Home address of Witness 1</td>
<td>Home address of Witness 2</td>
</tr>
<tr>
<td>City, State, Zip Code of Witness 1</td>
<td>City, State, Zip Code of Witness 2</td>
</tr>
</tbody>
</table>

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

State of __________________________  County of __________________________
This document was subscribed and sworn to before me by the Declarant,

And (names of witnesses) _____________________________________________________________________________

as the fully voluntary act and deed of the Declarant on (date)

My commission expires: ____________________________________________
Notary Public:

Any inserted pages should come before the final Signature Page. [End of Document]