**PSYCHIATRIC ADVANCE DIRECTIVE**

**XXXX XXXX**

**X/XX/XXXX**

**Contents**

1. Information for Law Enforcement and Crisis Workers…………………………………...2

2. Veteran Status……………………………………………………………………………..3

3. Declaration for Mental Health Treatment in a Psychiatric Hospital....……………………4

 Informed Consent to Treatment Even if Not Legally Incapacitated………………………4

 a. Psychoactive Medication Treatment………………………………………………5

b. Convulsive Treatment……………………………………………………………..6

c. Preferences for Emergency Treatment………………………………………….....7

4. Directives if I am Hospitalized…..... …………………………………………………......8

a. Who should be notified upon my admission to a psychiatric hospital…..………..8

b. The identity of my next of kin…………………………………………………….8

c. The identity of my medical power of attorney….…………………………………9

d. Revocation or termination of this agreement………………………………….......9

e. Personal items I would like if I am hospitalized…………………………………..9

f. Household matters……………………………………………………………….10

g. Finances………………………………………………………………………….10

h. Employment……………………………………………………………………..10

5. Signature Page and Witnesses…………………………………………………………...11

6. Individuals Who Have Copies of this Document………………………………………..12

**INFORMATION FOR LAW ENFORCEMENT AND CRISIS WORKERS**

**XXXX XXXX**

**XX/XX/XXXX**

**I am an Afghanistan combat veteran. I HAVE PTSD.**

**I am qualified to receive medical and mental health care through the Veterans Health Administration.**

*[Add in relevant VA information here.]*

Things that may help de-escalate the situation:

1. Please contact a mental health deputy.
2. Please do not come close to me. Please keep a minimum distance of 30 feet.
3. Please remain in front of me. Please stay within my direct line of sight. Please do not move beyond 45 degrees to either side of my body.
4. Please tell me we are not in Afghanistan.
5. Please tell me the month, day and year.
6. Please say my first name as often as possible.

Things that may escalate the situation:

1. Please avoid physical contact as much as possible.
2. If you are going to touch me, please tell me you are going to do so and give me a chance to prepare.
3. Please do not move out of my direct line of sight. Please do not move beyond 45 degrees to either side of my body.
4. Please do not stand behind me.
5. Please do not block me in with my back against a wall.
6. Please do not use yell.

**VETERAN STATUS**

I am qualified to receive medical and mental health care through the Veterans Health Administration.

*[Add in relevant information here.]*

**DECLARATION FOR MENTAL HEALTH TREATMENT**

**IN A PSYCHIATRIC HOSPITAL**

**INFORMED CONSENT TO TREATMENT EVEN IF**

**NOT LEGALLY INCAPACITATED**

I, XXXX XXXXX, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by a court, or by a medical professional, that my ability to understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment, is impaired to such an extent that I lack the capacity to make mental health treatment decisions. "Mental health treatment" means electroconvulsive or other convulsive treatment, treatment of mental illness with psychoactive medication, and preferences regarding emergency mental health treatment.

In the event that a guardian or other decision-maker is appointed by a court to make health care decisions for me, I intend this document to take precedence over all other means of ascertaining my intent while competent.

By this document, I intend to create a declaration for mental health treatment as authorized by Texas Mental Health Code, CPRC § 137.002, 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.

A physician or other health care provider shall act in accordance with my wishes in this Declaration for Mental Health Treatment if I am found to be incapacitated by a court or by a medical professional. If I am not incapacitated, a physician or other provider shall continue to seek and act in accordance with my informed consent if I am capable of providing informed consent. Texas Mental Health Code, CPRC § 137.004.

On being provided a copy of this Declaration for Mental Health Treatment, a physician or other health care providers shall make the declaration a part of my medical record. A physician or other health care provider shall comply with my wishes as expressed in this Declaration for Mental Health Treatment to the fullest extent possible. Texas Mental Health Code, CPRC § 137.007(a).

My wishes expressed in this document supersede any contrary or conflicting instructions given by a durable power of attorney or a guardian. Texas Mental Health Code, CPRC § 137.009 (a)(1); 137.009(a)(2).

My wishes regarding medication preferences as expressed in this document shall be used as my preference in a medication hearing under Texas Health and Safety Code, CPRC § 574.106; 137.009(b).

**PSYCHOACTIVE MEDICATIONS**

If I become incapable of giving or withholding informed consent for medical and/or mental health treatment, my wishes regarding psychoactive medications are as follows:

I consent to the use of the following medications **(Example):**

1. Zyprexa. It is very important that I do not miss my Zyprexa injection. I receive the injection the third Tuesday of every month. I notice an increase in mental health struggles a few days prior to the injection.
2. Wellbutrin.
3. Vistaril.
4. Trazodone. See conditions or limitations below.
5. Crisis is often not about my medication and adjustments may be unhelpful. Hospitalization helps me through a crisis by providing safety and a schedule.
6. I may be willing to try recommended medications, but please listen to me and respect decision if I say I don’t like the medication and do not want to take it.
7. Please contact my (insert local LMHA or family member) for my current list of medications.

Trazodone conditions or limitations: I only consent to a 50 mg or less dose of trazodone.

I do not consent to the following medications **(Example):**

1. Haldol. Haldol makes me feel terrible. I can’t think straight, make decisions, or hold conversations.
2. Benzodiazepines. I was addicted to benzodiazepines for 10 years. It was difficult to detox. DO NOT GIVE ME BENZODIAZEPINES.
3. Risperdal. Risperdal does not work for me. It makes my symptoms worse and it makes me shake.
4. Lithium. I had lithium toxicity in 1998. I was hospitalized for a three week due to the lithium toxicity. Lithium also makes my skin feel like it is burning.

**CONVULSIVE TREATMENT**

If I become incapable of giving or withholding informed consent for medical or mental health treatment, my wishes regarding convulsive treatment are as follows:

**Example 1**

I do notconsent to the administration of convulsive treatment.

Conditions or limitations: There are no conditions or limitations. I do **not** consent to convulsive treatment.

**Example 2**

I consent to the administration of convulsive treatment **only** under the following conditions:

Conditions or limitations: My mother, XXXXX XXXXX, (XXX) XXX-XXXX, may consent on my behalf to convulsive treatment. I waive HIPAA only for the purpose of my mother consulting with the medical and mental health personnel necessary for her to make an informed decision regarding convulsive treatment. My mother’s consent for convulsive treatment must be obtained for each hospitalization.

If my mother consents for me to receive convulsive treatment, I only consent to three treatments total per hospitalization.

**PREFERENCES FOR EMERGENCY TREATMENT**

In an emergency, I prefer the treatment in the following order:

FIRST: Medications

SECOND: Seclusion

THIRD: Restraint

Options for treatment prior to use of medications, seclusions and/or restraint:

Prior to the use of medications, seclusion or restraint, I would like staff to try to communicate with me in the following manner and/or try the following techniques to de-escalate the situation:

1. **Listening = Helping.**
2. Please speak to me in a soft tone of voice.
3. Please speak to me in a low volume.
4. Please speak to me separately.
5. Please give me as much space as possible.
6. Please let me see the door.
7. Please do not block my access to the door.
8. Please keep law enforcement or people in law enforcement style uniforms out of sight.
9. Please stay on the same level as me. Please do not stand over me.
10. Please listen. Please let me tell talk about what is going on without interruption.
11. Please don’t try to fix me or offer suggestions or solutions. Please listen.
12. **Listening = Helping.**

**DIRECTIVES IF I AM HOSPITALIZED**

**A. Statement of My Preferences Regarding Notification of Others**

If I am inside a medical or mental health facility of any kind, whether public or private, including, but not limited to, emergency rooms, psychiatric hospitals, medical hospitals, psychiatric units or wings of medical hospitals, crisis stabilization units, county jails or Texas Department of Criminal Justice institutions, I direct hospital staff to notify the following individuals immediately by telephone. I waive my privacy rights under the Health Insurance Portability and Protection Act for the purpose of this notification only.

XXXXX XXXXX (XXX) XXX-XXXX

XXXXX Loop Lane

Texas

XXXXXX XXXXX (XXX) XXX-XXXX

XXXX Loop Lane

Texas

If I am inside a medical or mental health facility of any kind, whether public or private, including, but not limited to, and whether public or private, emergency rooms, psychiatric hospitals, medical hospitals, psychiatric units or wings of medical hospitals, crisis stabilization units, county jails or Texas Department of Criminal Justice institutions, regardless of whether I have been appointed an attorney, I direct hospital staff to provide me with a telephone so that I may contact an attorney of my choice.

Texas RioGrande Legal Aid

(xxx) xxx-xxxx

***Any attorney who has been appointed to represent me or any attorney I retain must be provided a copy of this document.***

**B. Identity of My Next of Kin**

Name:

Relationship:

Address:

Phone:

Name:

Relationship:

Address:

Phone:

**C. The Identity of My Medical Power of Attorney**

I have executed a Medical Power of Attorney. The Medical Power of Attorney should go into effect if I become incapable of giving consent to medical or mental health care treatment.

The contact information for my Medical Power of Attorney is: / and alternate Medical Power of Attorney are:

Name: [Agent’s Name]

Address: [Agent’s Address, City, State, Zip]

Phone Number: [(XXX) XXX-XXXX]

Alternate:

Name: [Agent’s Name]

Address: [Agent’s Address, City, State, Zip]

Phone Number: [(XXX) XXX-XXXX]

**D. Statement of My Preference Regarding Revocation or Termination of This Declaration for Mental Health Treatment**

1. Revocation of My Declaration for Mental Health Treatment During a Period of Incapacity

In accordance with Texas Mental Health Code, CPRC § 137.010, my wish is that this mental health care directive may be revoked, suspended or terminated by me only at times that I have the capacity and competence to do so.

2. Notwithstanding the above, it is my wish that my agent or other decision-maker specifically ask me about my preferences before making a decision regarding mental health care and take the preferences I express here into account when making such a decision, even while I am incompetent or incapacitated.

**E. Personal items I would like to have in the hospital.**

If I have not been able to do so, I would very much appreciate my wife packing a bag with the following items:

1. Pants (3)
2. Shirts (3)
3. Underwear (3)
4. Socks (3)
5. Pajamas
6. Flip Flops
7. Toothpaste and Toothbrush
8. Comb
9. Mint tea
10. Fidget spinner

**F. Household**

Example: I would like for my sister, XXXX XXXX, to pay my rent and bills. I would like my sister, XXXX XXXX, to handle the GI form for housing.

Example: I would like for my sister, XXXX XXXX, to take care of my cat and my plants. She has a spare key.

Example: I would like for my sister, XXXX XXXX, to collect and review my mail and take care of anything that must be handled while I am in the hospital.

**G. Finances**

I authorize my sister, XXXX XXXX, to access any account in my name at any financial institution. I authorize my sister, XXXX XXXXX, to act on my behalf for any financial situations which may arise.

**H. Employment**

I would like my sister, XXXX XXXX, to contact my employer, XXX XXXX, and let him know that I am in the psychiatric hospital.

**SIGNATURE PAGE AND WITNESSES**

By signing here I indicate that I understand the purpose and effect of this document and each of the parts therein.

XXXX XXXXXX Date

The Psychiatric Advance Directive was signed, initialed and declared by “Declarant,” XXXX XXXXXX, in our presence who, at his request, have signed names below as witnesses. We declare that, at the time of the execution of this instrument, the Declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further declare that none of us is: 1) a physician; 2) the Declarant’s physician or an employee of Declarant’s physician; 3) an employee or patient of any residential health care facility in which the Declarant is a patient; 4) designated as agent, alternate, or proposed guardian under this document; or 5) a beneficiary or creditor of the estate of Declarant.

Dated at County, Texas this \_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_ , 2019.

Witness Signatures

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Witness 1, Signature Date

Witness 1, Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Witness 2, Signature Date

Witness 2, Printed Name

**INDIVIDUALS WHO HAVE COPIES OF THIS DOCUMENT**

I have given copies of this document to:

Name Address or phone

Name Address or phone

Name Address or phone

Name Address or phone

Name Address or phone

Name Address or phone