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7800 Shoal Creek Boulevard, #171-E, Austin, Texas 78757-1014
1-800-252-9108 (Intake)
512-454-4816 (Main Office) 512-323-0902 (Fax)
info@disabilityrightstx.org • www.DisabilityRightsTx.org

EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

HOW TO MAKE AN ADVANCED DIRECTIVE

Texas law allows you to create a Declaration for Mental Health Treatment ("Declaration" [commonly called an "Advance Directive"]) to control your mental health (MH) treatment in the event you become unable to make treatment decisions at a later date. A Declaration is a legal document. It lets you write down information about three (3) kinds of treatment you may or may not want to be used as part of your MH treatment in the future, when you can't make those decisions yourself due to illness, or for some other reason. The three kinds of treatment you can give instructions about are: **what psychotropic medications you do or do not want; if you do or do not want electroconvulsive treatment (ECT); and, if an emergency comes up, how you would like the doctors and staff to try to calm you down**, e.g., let you read a book, give you a shot of medication, and then try seclusion. It also contains spaces for conditions and limitations in which you include exactly what you want in regard to the three MH treatments listed above.

Once a Declaration is created and signed, it is difficult to change or cancel, so if you decide you want a Declaration, you should discuss this decision with a doctor, a lawyer, family, and friends whom you trust completely to help you make good decisions.

Your Declaration will be used when you are found incapable of making your own MH treatment decisions. Incapable means that a judge in a guardianship proceeding or a judge at a medication hearing has decided that you cannot make MH treatment decisions for yourself.

To make a Declaration, you must fill out a ***Statutory Form*** (copy attached) when you are competent. Competent means that a judge has not said that you can't make medical decisions. **To be legally *possible* for it to be used as your instructions about MH treatment, the Declaration must be signed and dated by you and two witnesses.** Anyone, **except the following people**, may be your two witnesses:

1. relatives;
2. attending doctor or the doctor's employees;
3. MH service provider including a community center or his employees; and/or
4. the owner or operator of a health care facility in which you are a patient or a resident, or his or her employees.

Take a copy of the executed Declaration with you when you enter a hospital or other facility. If the doctors don't have a copy and don't know it exists, they will not be able to follow your treatment instructions.

Your Declaration is valid and in force for *three years* from date you and your witnesses sign it unless:

1. it is extended because you are found to be incapable of making MH treatment decisions at the end of the three years;
2. you cancel it; or
3. you execute a new Declaration. If you are still capable three years after it has been signed, it will automatically run out. If you want to continue your Declaration at the end of three years, you will have to make a new Declaration.

A Declaration **cannot be revoked or canceled, once you are determined to be incapable. If you are found incapable** of making MH treatment decisions at the end of three years, **it will continue to be used** for as long as you are found incapable. To be found capable again,

1. a court must declare that you competent,
2. you are released from the hospital, or
3. a doctor evaluates you and determines that you are capable of making your own MH treatment decisions.

You can cancel your Declaration when you are capable by doing any of the following:

1. write a statement canceling your Declaration;
2. tear it up, mark an "X," or write canceled on the Declaration;
3. inform your treating doctor that you wish to cancel your Declaration;
4. make a new Declaration; or
5. your Declaration will automatically be canceled three years after it was executed, if you are capable at that time.

Your Declaration will not be used if you have not been found incapable of making treatment decisions; anyone who treats you must inform you of the benefits and risks of treatment, and follow your decision on how you want to be treated. This is called giving informed consent to treatment, and means that the doctor must rely on what you say--not on your Declaration. **When you are on a voluntary commitment, a doctor cannot use your Declaration.** It also won't be used:

1. if it is found that you are about to hurt yourself or others right then, it may be called an emergency and you may be given psychotropic medication or restrained if, after they follow your Directive, the emergency is still there; and/or
2. if a court orders that you be given medications, even though the medications are different from those in your directive.

You cannot be forced to create a Declaration because the law says a Declaration is to be created and signed voluntarily. This means you cannot be forced to sign a Declaration in order to get treatment, to get out of a MH facility, or for any reason other than that you want to control the MH treatment you will receive.

For more information on how to fill out a Declaration,
please request Disability Rights Texas' Advance Directive handbook.

DECLARATION FOR MENTAL HEALTH TREATMENT

I, _____, 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 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 electro convulsive or other convulsive treatment, treatment of mental illness with psychoactive medication, or preferences regarding emergency mental health treatment.

(OPTIONAL:)
I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

PSYCHOACTIVE MEDICATIONS

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

____ I consent to the administration of the following medications:

____ I do not consent to the administration of the following medications:

____ I do consent to the administration of a Federal Drug Administration (FDA) approved medication that was only approved and in existence after my declaration and that is considered in the same class of psychoactive medications as stated below:

Conditions or limitations:

CONVULSIVE TREATMENT

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

____ I consent to the administration of convulsive treatment.

____ I do not consent to the administration of convulsive treatment:

Conditions or limitations:

PREFERENCES FOR EMERGENCY TREATMENT

Options for treatment prior to use of restraint, seclusion and /or medications.

_____

_____

_____.

Conditions or limitations:

OPTIONAL

In an emergency, I prefer the following treatment

FIRST: **(circle one)**

Restraint/Seclusion/Medication

OPTIONAL
In an emergency, I prefer the following treatment

SECOND: **(circle one)**

Restraint/Seclusion/Medication

OPTIONAL

In an emergency, I prefer the following treatment

THIRD: **(circle one)**

Restraint/Seclusion/Medication

_____ I prefer a male/female to administer restraint, seclusion and/or medications.

ADDITIONAL REFERENCES OR INSTRUCTIONS

Conditions or limitations:

_____
SIGNATURE OF PRINCIPAL

_____
DATE

STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal's name has been represented to me by the principal, that the principal signed or acknowledged this declaration in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, and that I am not a provider of health or residential care to the principal, an employee of a provider of health or residential care to the principal, an operator of a community health care facility providing care to the principal, or an employee of an operator of a community health care facility providing care to the principal.

I declare that I am not related to the principal by blood, marriage or adoption and that to the best of my knowledge I am not entitled to and do not have a claim against any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness Signature:_____
Print Name:_____
Date:_____
Address:_____

Witness Signature:_____
Print Name:_____
Date:_____
Address:_____

NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about mental health treatment and specifically three types of mental health treatment: psychoactive medication, convulsive therapy and emergency mental health treatment. The instructions that you include in this declaration will be followed only if a court believes that you are incapable of making treatment decisions. Otherwise, you will be considered able to give or withhold consent for the treatments.

This document will continue in effect for a period of three years unless you become incapacitated to participate in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapacitated.

You have the right to revoke this document in whole or in part at any time you have not been determined to be incapacitated. **YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED BY A COURT TO BE INCAPACITATED.** A revocation is effective when it is communicated to your attending physician or other health care provider.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration is not valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

Disability Rights Texas' goal is to make each handout understandable by and useful to the general public. If you have suggestions on how this handout can be improved, please contact Disability Rights Texas at the address and telephone number shown above e-mail our agency at info@disabilityrightstx.org. Thank you for your assistance. This handout is available in Braille and/or on audio tape upon request. Disability Rights Texas strives to update its materials on an annual basis, and this handout is based upon the law at the time it was written. The law changes frequently and is subject to various interpretations by different courts. Future changes in the law may make some information in this handout inaccurate. The handout is not intended to and does not replace an attorney's advice or assistance based on your particular situation.