Declaration For Mental Health Treatment

Understanding your mental health declaration

What this form does

- This form lets you plan your mental health care if you can’t make decisions later.
- This form **only** applies if a **court** or **two capacity evaluators** decide you can’t make decisions.
- You can:
  - » Say what treatments you want or don’t want
  - » Agree to or refuse to go to certain facilities
  - » Pick someone you trust to decide for you if needed

Key terms

- **Mental health treatment** includes:
  - » Medicines
  - » Short stays up to 17 days
  - » Convulsive therapy
  - » Outpatient services
- **Incapable**: When a court or two capacity evaluators say you can’t understand your mental health care. They also say you can’t communicate well enough to make decisions.
- **Representative**: The person you choose to decide for you if you can’t. They must follow your wishes or act in your best interest.

Signatures

- You must sign the form for it to work.
- **Two** witnesses must sign:
  - » They must know you
  - » They must not be related to you
  - » They must not provide your care
- Your representative must sign to agree to serve.

Your choices

- You can cancel this form **at any time you are capable**.
- It lasts **three years**, unless you become incapable. If that happens, it stays in effect until you become capable again.
- Doctors **must** follow your instructions or stop treatment and tell you why.

Your mental health declaration

I, ____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment. I want this declaration to be followed if a court or two capacity evaluators determine that I am unable to make decisions for myself because my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment.

Definitions

"**Mental health treatment**" means:

- Psychoactive medication
- Admission to and retention in a health care facility for a given period
- Convulsive treatment
- Outpatient services specified in this declaration

"**Health care facility**" could include:

- An inpatient setting
- A residential facility
- An adult foster home
- A hospice program

"**Capacity evaluator**" means a licensed independent practitioner or a licensed psychologist.

Choice of decision maker

If I become incapable of giving or withholding informed consent for mental health treatment, I want these decisions to be made by (initial ONE only):

My appointed representative consistent with my desires, or, if my desires are unknown by my representative, in what my representative believes to be my best interests.

The mental health treatment provider who requires my consent to treat me, but **only** as specifically authorized in this declaration.

Appointed representative(s)

Primary representative

If I have chosen to appoint a representative to make mental health treatment decisions for me when I am incapable, I am naming that person here. I may also name an alternate representative to serve. Each person I appoint must accept my appointment to serve. I understand that I am not required to appoint a representative in order to complete this declaration.

I hereby appoint:

Name: ______________________________

Address: ______________________________

Phone: ______________________________

This person will act as my representative to make decisions about my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

Alternate representative

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my representative, I authorize the following person to act as my representative:

Name: ______________________________

Address: ______________________________

Phone: ______________________________

My representative(s) are authorized to:

- Make decisions consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my representative.
- Act in what he or she believes to be my best interests, if my desires are not expressed and are not otherwise known by my representative.
- Receive information about proposed mental health treatment.
- Receive, review and consent to disclosure of medical records relating to that treatment.

Directions for mental health treatment

This declaration permits me to state my wishes regarding mental health treatments including:

- Psychoactive medications
- Admission to and retention in a health care facility for mental health treatment for a period not to exceed the number of days specified below

- Convulsive treatment
- Outpatient services

Treatment facilities

If I become incapable of giving or withholding informed consent to be admitted for inpatient mental health treatment, **I consent to be admitted to the following health care facilities**:

Facility: ____________________

Address: ____________________

Facility: ____________________

Address: ____________________

Facility: ____________________

Address: ____________________

Treatment timing

IF I become incapable of giving or withholding informed consent to be admitted to a health care facility for mental health treatment, and am admitted to a facility listed above, I consent to be admitted when medically necessary for up to:

Duration (choose only ONE):

14 days

30 days

60 days

Other number of days: ________

Mental health treatments

If I become incapable of giving or withholding informed consent for mental health treatment, **I consent to the following mental health treatments** (May include types and dosage of medications, short-term inpatient treatment, a preferred provider or facility, transport to a provider or facility, convulsive treatment or alternative outpatient treatments.):

Mental heath treatments, continued

I do not consent to the following mental health treatment (Consider including your reasons, such as past adverse reaction, allergies or misdiagnosis. Be aware that a person may be treated without consent if the person is held pursuant to a **court order**):

Additional information about my mental health treatment needs

Consider including mental or physical health history, dietary requirements, religious concerns, people to notify and other matters of importance:

Signatures

Client acceptance of this declaration

You must sign here for this declaration to be effective:

Client signature	Printed name	Date signed

Notary or witnesses (choose ONE option)

You must complete **either** Option 1 **OR** Option 2 below:

Option 1: Notorial Certificate

Apply notorial stamp here:

State of: ______________________________

County of: ____________________________

Signed or attested before me on: ____________________,
Month and day

20_______, by ____.
Year Notary Public name

____
Notary Public of Oregon signature

Option 2: Affirmation of Witnesses

Have **two competent adult witnesses** complete the following affirmation:

I affirm that the persons signing this declaration:

1. **Are** personally known to me, and they:
   - Signed or acknowledged their signatures on this declaration in my presence, and
   - Appear to be of sound mind and not under duress, fraud or undue influence;
2. **Are not** related to me by blood, marriage or adoption;
3. **Are not** a patient or resident in a facility that I or my relative owns or operates;
4. **Are not** my patient and do not receive mental health services from me or my relative; and
5. **Has not** appointed me as a representative in this document.

Witnessed by (two witnesses required):

Witness signature	Printed name	Date signed

Witness signature	Printed name	Date signed

Acceptance of appointment as representative

I accept this appointment and agree to serve as representative to make mental health treatment decisions. I understand that:

- I must act consistently with the desires of the person I represent, as expressed in this declaration or, if not expressed, as otherwise known by me.
- If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest.
- This document gives me authority to make decisions about mental health treatment only while that person has been determined to be incapable of making those decisions by a court or two capacity evaluators.
- The person who appointed me may revoke this declaration in whole or in part by communicating the revocation to the attending physician or other provider when the person is not incapable.

Primary representative signature	Printed name	Date signed
Alternate representative signature	Printed name	Date signed

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 certain types of mental health treatment:
  - Psychoactive medication
  - Short-term (not to exceed the number of days you indicate above) admission to a treatment facility
  - Convulsive treatment
  - Outpatient services

Outpatient services are mental health services provided by appointment by licensed professionals and programs.

- The instructions that you include in this declaration will be followed only if a court or two capacity evaluators believe you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.
- Your instructions may be overridden if you are being held pursuant to a court order.
- You may also appoint a person as your representative to make treatment decisions for you if you become incapable. The person you appoint has a duty to act consistently with your desires as stated in this document or, if not stated, as otherwise known by the representative. If your representative does not know your desires, he or she must make decisions in your best interests.

- For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your representative at any time.
- A “representative” is also referred to as an “attorney-in-fact” in state law but this person does not need to be an attorney at law.
- This declaration continues in effect for three years unless you become incapable. If that occurs, the directive will continue in effect until you are no longer incapable.
- You have the right to revoke this document in whole or in part at any time you have not been determined to be incapable. **You may NOT revoke this declaration when you are considered incapable by court or two capacity evaluators**. Revocation is effective when communicated to your attending physician or other 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 will not be valid unless it is signed by a notary or two qualified witnesses who are personally known to you and present when you sign or acknowledge your signature.

Notice to physician or provider

- Under Oregon law:
  - » This declaration may be used to provide consent for mental health treatment or to appoint a representative when the person is incapable.
  - » A person is “incapable” when, in the opinion of a court or two capacity evaluators, they lack the ability to make mental health treatment decisions due to impairment in receiving and evaluating or communicating information.
- This document becomes operative when delivered to the person’s physician or other provider. It remains valid until revoked or expired.
- Upon presentation, a physician or provider must make it a part of the person’s medical record. When acting under its authority, the physician or provider must comply to the fullest extent possible. If unwilling to comply, the physician or provider may withdraw from providing treatment, consistent with professional judgment, and must promptly notify the person and their representative and documenting the notification in their record.
- A physician or provider who administers or does not administer mental health treatment in good faith reliance on the validity of this declaration is not subject to criminal prosecution, civil liability or professional disciplinary action due to a later finding of invalidity.

Get help with this form

For questions or help completing this form, please contact the local community mental health program (CMHP) you work with.

Look up your local CMHP here: www.Oregon.gov/CMHP

For more information contact:

Disability Rights Oregon

610 SW Broadway, Suite 205
Portland, Oregon 97205
503-243-2081

Oregon Law Center

https://www.OregonLawCenter.org
Oregon Public Benefits Hotline: 1-800-520-5292

National Alliance on Mental Illness (NAMI) Oregon

147 SE 102nd Ave
Portland, OR 97216
https://www.namiOR.org
Phone: 503-230-8009 or 800-343-6264 (not a crisis line)
Email: namioregon@namior.org