Declaration for Mental Health Treatment

Attention: This is a legal document which contains important information regarding the affected person's preferences or instructions for mental health treatment.

Declaration for Mental Health Treatment

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 physicians 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. "Mental health treatment" means treatment of mental illness with psychoactive medication, admission to and retention in a health care facility for a period up to 17 days, convulsive treatment and outpatient services that are specified in this declaration.

Choice of Decision Maker

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

____ 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.

____ By the mental health treatment provider who requires my consent in order to treat me, but only as specifically authorized in this declaration.

Appointed Representative

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

I hereby appoint: NAME_____

ADDRESS_____

_____

TELEPHONE #_____

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

(OPTIONAL)

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_____

_____

TELEPHONE #_____

My representative is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my representative. If my desires are not expressed and are not otherwise known by my representative, my representative is to act in what he or she believes to be my best interests. My representative is also authorized to receive information regarding proposed mental health treatment and to 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 are facility for mental health treatment for a period not to exceed 17 days, convulsive treatment and outpatient services.

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes are: **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.)

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 civil commitment law.)

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.)

YOU MUST SIGN AND DATE HERE FOR THIS DECLARATION TO BE EFFECTIVE:

Signature and Date:_____

Affirmation of Witnesses

I affirm that the person signing this declaration:

(a) Is personally known to me;
(b) Signed or acknowledged his or her signature on this declaration in my presence;
(c) Appears to be sound mind and not under duress, fraud or undue influence;
(d) Is not related to me by blood, marriage or adoption;
(e) Is not a patient or resident in a facility that I or my relative owns or operates;
(f) Is not my patient and does not receive mental health services from me or my relative; and
(g) Has not appointed me as a representative in this document.

Witnessed by:

_____

[Signature of Witness (Printed Name of Witness)/Date]

_____

[Signature of Witness (Printed Name of Witness)/Date]

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. I understand that 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 physicians. I understand that 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.

_____

[Signature of Representative (Printed name) and Date]

_____

[Signature of Alternate Representative (Printed name) and Date]

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 17 days) admission to a treatment facility, convulsive treatment and 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 physicians believe that 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 civil commitment law.

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 document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this 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 A COURT OR TWO PHYSICIANS.*** A revocation is effective when it is 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 two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

Notice to Physician or Provider

Under Oregon law, a person may use this declaration to provide consent for mental health treatment or to appoint a representative to make mental health treatment decisions when the person is incapable of making those decisions. A person is "incapable" when, in the opinion of a court or two physicians, the person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions. This document becomes operative when it is delivered to the person's physician or other provider and remains valid until revoked or expired. Upon being presented with this declaration, a physician or provider must make it a part of the person's medical record. When acting under authority of the declaration, a physician or provider must comply with it to the fullest extent possible. If the physician or provider is unwilling to comply with the declaration, the physician or provider may withdraw from providing treatment consistent with professional judgment and must promptly notify the person and the person's representative and document the notification in the person's medical record. A physician or provider who administers or does not administer mental health treatment according to and in good faith reliance upon the validity of this declaration is not subject to criminal prosecution, civil liability or professional disciplinary action resulting from a subsequent finding of the declaration's invalidity.

This Guide to Oregon's Declaration for Mental Health Treatment and Form was developed pursuant to Oregon Revised Statutes (ORS) 127.700 through 127.736.

For additional information contact:

Oregon Health Authority
Addictions and Mental Health Division
500 Summer Street NE, E-86
Salem, Oregon 97301
503- 945-9716

NAMI-Oregon
4701 SE 24th Ave., Suite E
Portland, OR 97202
503-230-8009

Disability Rights Oregon
610 SW Broadway, Suite 200
Portland, OR 97205
503-243-2081

Here is a card you can fill out and carry with you:

Emergency Medical Information
Name: _____
I have written a **Declaration for Mental Health Treatment** which is on file at:

_____
Immediately contact my Representative at:

_____
Name Phone
or Alternate Representative at:

_____
Name Phone

ACKNOWLEDGMENTS

Authored in 1994 by:

Patricia Backlar
Center for Ethics in Health Care
Oregon Health Sciences University

Editorial Board:

Brett D. Asmann, M.A.
Project Coordinator

Mary Alice Brown, Ph.D.

Roderick Calkins, Ph.D.

Nellie Fox-Edwards

Gary Cornelius

Theodore Falk, J.D., Ph.D.

Michael Garland, D.Sc. Rel.

Rex Surface, M.S.W.

Robert C. Joondeph, J.D.
Authored Instructions

Richard C. Lippincott, M.D.

Sandra Millius

Linda O'Mallia, M.C.S.W., B.C.D.

Garrett Smith, M.P.A.

Gary Smith, M.S.

Stanley Sturges, M.D.

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Updated by:

Robert C. Joondeph, J.D., Oregon Advocacy Center
Jan E. Friedman, J.D., Oregon Advocacy Center
Bob Nikkel, Office of Mental Health and Addiction Services
Jamie Rockwell, Office of Mental Health and Addiction Services

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