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# **Can I Plan Now For The Mental Health Treatment I Would Want If I Were In Crisis?**



## **A Guide to Oregon's Declaration for Mental Health Treatment**

**Oregon  
Health  
Authority**

**ADDICTIONS AND MENTAL HEALTH DIVISION**

This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact AMH at 503-945-5763 or 1-800-875-2863 (TTY).

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## ANSWERS TO QUESTIONS

### Planning for Your Mental Health Treatment

#### Can I plan now for the mental health treatment I would want if I were in crisis?

Yes. You can plan now for a time when you may be unable to make your own mental health treatment decisions.

#### How can I plan ahead?

Oregon has a form that you can fill out and sign now to protect yourself when you may be in crisis and are unable to make your own treatment decisions. This form is called a **Declaration for Mental Health Treatment**.

#### Who decides if I am unable to make my own treatment decisions?

Only a court or two physicians can decide if you are unable to understand and make decisions about your mental health treatment.

*A **Declaration** form is used only when you are unable to understand and make decisions about your mental health treatment.*

#### What kind of advance planning does Oregon's Declaration for Mental Health Treatment allow me to make?

You can make choices about your future mental health care. You can describe the kind of care that you want to receive. You can also describe the kind of care you do not want to receive.

You can also provide additional information about your mental health treatment needs.

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*It is wise to prepare this part of the **Declaration** carefully. You may want to discuss this section with your physician or mental health provider.*

**Can I ask someone to speak for me when I am in crisis and can't speak for myself?**

Yes. You can choose an adult to represent you. This should be someone you trust who can make decisions about your mental health care when you cannot do so for yourself. Of course, the person you name must agree to do so.

On the **Declaration** form the person you choose is called a Representative.

**Do I have to choose a lawyer?**

No.

**Can my representative make mental health treatment decisions that change my own wishes for treatment?**

No. Your representative must follow your wishes. It is wise to talk to your representative about your wishes.

Even if you have not made your wishes known, your representative must make decisions for that are as close as possible to the kind of decision you would make yourself if you were capable of doing so.

Your physician is not required to give you the medicine you have chosen in your **Declaration** form if your physician believes that it is not good for you. However, your physician must have your representative's *permission* to give you a medicine that is *not listed* in the **Declaration**.

*This is why it is important for you to choose someone who knows you well and whom you trust.*

## How can I make sure that my instructions will be followed?

In order for your instructions to be followed, you or your representative *must* give copies of your completed **Declaration** form to your physician or mental health provider. Your representative should keep a copy, and it is wise to keep a copy for yourself.

## Can my instructions ever be changed?

Whether or not you have signed a **Declaration** form, if you are on an emergency psychiatric hold, or if you have been committed by a court, your physician may still give you medicine that you didn't want. Your physician can only do this under very strict legal guidelines.

## If I make out and sign a Declaration for Mental Health Treatment will it be good forever?

No. A signed **Declaration for Mental Health Treatment** only will be valid for 3 years and must be renewed. However, should you become incapable of making mental health treatment decisions during these 3 years the **Declaration** will remain until the time — whenever that may be — that you regain capacity to make your own decisions.

## Can I change my written instructions for mental health treatment or cancel my Declaration form?

Yes. As long as you are able to understand the information given to you about the choices that you may make for your mental health treatment, you may change your written mental health treatment instructions or cancel your **Declaration** form.

Of course, in order to make sure that your wishes are followed, you *must* give your physician or mental health provider a new **Declaration** form that includes the changes you wish.



However, if a court or two physicians decide that you are *unable to understand your mental health treatment options and you are not capable of making choices about your mental health treatment*, you will not be permitted to change your written instructions or to cancel your **Declaration** until the time that you regain capacity to understand your treatment options.

But, this is why you have written out your future wishes on this **Declaration for Mental Health Treatment** form: *You want to protect yourself when you are in crisis and are unable to make your own treatment decisions.*

**If I move out of the state of Oregon, will my Declaration form be valid?**

It depends on where you go. Each state has its own rules.

**Can anyone force me to make out a Declaration for Mental Health ?**

No. *No one*, no insurer, no physician, no mental health treatment provider, nor any other person is permitted to attempt to force you to make out a **Declaration** form. It should be your *free choice* to make out and sign the **Declaration for Mental Health Treatment**.

Witnesses who sign your **Declaration** form should be people whom you know and trust. They can verify that you signed the form by your own free choice, *without being forced*.

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## INSTRUCTIONS

It is entirely your choice as to whether or not you want to have a **Declaration For Mental Health Treatment (Declaration)**.

Before you fill out your **Declaration**, you should carefully read the “NOTICE TO PERSON MAKING A **Declaration** FOR MENTAL HEALTH TREATMENT” as well as the “NOTICE TO PHYSICIAN OR PROVIDER,” which are found on pages 8 through 9 of the **Declaration** form. These notices give you some general information about the **Declaration**.

Once you make your **Declaration**, it stays in effect for three years unless you revoke it. After three years, it is not valid. You need to sign a new **Declaration**. If you are incapable at the end of three years to sign a new **Declaration**, the **Declaration** stays in effect until you are capable again.

If you decide that you do not want to have a **Declaration** or you want to change it, you can. To revoke the **Declaration**, you tell your doctor, your provider and anyone else who has your **Declaration** that you do not want it to be in effect. To be safe, you should do this in writing or get all the copies of the **Declaration** and tear them up. Also, you cannot revoke your **Declaration** during a time when you have been found incapable.

If there is anything in this document that you do not understand after reading the notices and the following instructions, then you should ask an attorney to explain it to you.

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# How To Fill Out A Declaration For Mental Health Treatment Form

## ***First Things First***

First, you must be mentally competent to make a **Declaration**. Second, you need an official form to fill out. You cannot make a legal **Declaration** without one, The form attached to these instructions is official and will be valid if it is correctly filled out, signed and witnessed.

To be valid and effective the form must:

- a. Contain your name.
- b. Be signed and dated by you.
- c. Be signed and dated by two witnesses who were present when you signed the **Declaration**. *They must believe you are mentally competent at the time you sign the form.*
- d. Contain your instructions about mental health treatment.

Follow these steps to make a legally valid ***Declaration for Mental Health Treatment***.

## ***Step 1 - Name***

Print or type your name legibly on the first line of the form after the word “I”.

## ***Step 2 - Choice of Decision Maker***

In the next section, you must choose who will make decisions for you if you become incapable of giving consent for mental health treatment. You can choose either the person who will be treating you or a “Representative”. Place your initials on the line next to your one choice.

Although the form does not say so, some people cannot act as your “Representative”. People who CANNOT be your “Representative” are:

- ▶ Your doctor, mental health service provider, or an employee of your doctor or provider, unless you are related to that person.
- ▶ An owner, operator, or employee of a health care facility where you live or are a patient, unless you are related to that person.

If you do not appoint a “Representative” or if the person you appoint does not accept appointment or is disqualified from serving, all of the other instructions in the **Declaration** are still valid.

### ***Step 3 - Appointed Representative***

If you choose a “Representative”, then fill in each blank with the information requested about that person on page 3 of the form. If you choose to designate someone to be the alternate to your “Representative”, then complete the information regarding the alternate “Representative” also on page 3 of the form.

### ***Step 4 - Directions For Mental Health Treatment***

The next part of the form, which is entitled “DIRECTIONS FOR MENTAL HEALTH TREATMENT” is where you put your instructions about the mental health treatment you want and don’t want. Your directions may include your wishes regarding medications, admission and staying at a mental health treatment facility (for no longer than 17 days), convulsive treatment as well as outpatient services. This section is divided into 3 separate parts, which are addressed in this instructions section as Step 4A, Step 4B and Step 4C.

## ***Step 4A - Mental Health Treatments That You Consent To***

On page 4 of the form, under the “DIRECTIONS FOR MENTAL HEALTH TREATMENT” is where you put instructions about what types of mental health treatment you want to approve. If you want specific instructions to be followed by a provider or your “Representative”, those instructions must be put here.

- ▶ If you want to give consent for certain types of drugs, then you should specify which particular medications you approve.
- ▶ If you want to give consent to any drug the doctor may recommend, state “I give consent for any medication that my doctor recommends for me.”
- ▶ If you want to limit your consent in any way, such as to maximum dosage, or you want certain information considered such as allergies you may have, you may add these instructions or information. You may specify your conditions or limitations. You may also state why a specific medication in a specified dosage should be used.
- ▶ If you have a “Representative”, it will be assumed that your “Representative” must consent to the dosage and type of medication.
- ▶ If you agree to short-term inpatient treatment, you may so specify. You may also specify the particular facility and/ or provider you consent to for this short-term inpatient treatment.
- ▶ You may agree to convulsive treatment, which includes “shock treatment” or “ECT”(Electroconvulsive treatment). If you want to make a decision in advance about this sort of treatment, you may do so in this section or in Step 4B. You may include a limitation on the number or type of treatments you consent to or a direction to consult your “Representative” for these decisions.

- ▶ If you state that you consent to any sort of mental health treatment, you will not necessarily receive it. A doctor must first recommend the treatment for your condition. Your consent does not give a doctor the right to make improper recommendations.

### ***Step 4B - Mental Health Treatments That You Do Not Consent To***

The next set of spaces for you to fill in on the form, at the top of page 5, is where you put instructions about what types of mental health treatment you do not consent to. If you want specific instructions to be followed by a provider or your “Representative”, then those instructions must be put here. You should be aware that you may be treated without consent if you are held pursuant to civil commitment law or are in an emergency situation where your life or health is endangered.

- ▶ If you do not want to give consent for certain types of drugs or dosage, state that “I do not consent to the administration of the following medications: ” and write down the names or types of drugs you are refusing.
- ▶ If you want to refuse to consent to taking all drugs, write: “I refuse to consent to taking all medications”.
- ▶ If you want to explain your refusal of consent, this can be specified. For example, you may corroborate your refusal by documenting the adverse effects, allergies or mis-diagnosis you have experienced from a particular medication and/ or mental health treatment.
- ▶ If you do not agree to short-term inpatient treatment, you may so specify. You may also specify that you do not agree to a particular facility and/or to a particular provider for this short-term inpatient treatment.
- ▶ If you do not agree to convulsive treatment and want to make a decision in advance about this sort of treatment, which includes “shock treatment” or “ECT” (Electroconvulsive treatment), you may so state.

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## ***Step 4C - Additional Information About Your Mental Health***

At the top of page 6 is where you put additional information about your mental health needs. You may include anything relevant to your wishes regarding your mental health treatment in this section. The form asks you to consider mental health history; physical health history; dietary requirements; religious concerns; people to notify; and other matters of importance. "Other matters of importance" could be anything related to the treatment that you feel may improve your mental health.

- ▶ For example, you can say, that when you are really upset, what calms you down the most is to sit quietly in a dark room, with the door left open. On the other hand, you can specify that the worst thing for you when you are really upset is to be placed in a locked room. The doctor does not have to follow these instructions, but if the doctor is aware of what works and what does not work, s/he may be willing to treat you according to your wishes.
- ▶ If you recognize through your experience that regular participation in a consumer run drop-in center provides you with the greatest sense of relief, then you can request that your therapy include participation in a consumer run drop-in center. Your choice does not guarantee that any such program will be available.
- ▶ If you would like to ensure that somebody is or is not told that you are in crisis/ in the hospital, then you may so specify.

## ***Step 5 - Your Signature***

Sign and date the form at the bottom of page 6. Do this in front of two witnesses. Your signature must appear in this place for any part of the directive to be effective.

## ***Step 6 - Affirmation of Witnesses***

Have your two witnesses sign and date the form on page 7 in the section headed "***Affirmation of Witnesses***".

Some people CANNOT act as witnesses. People who CANNOT act as your witnesses include:

- ▶ Your "Representative" or alternate "Representative". Anyone you appoint in Step 2 ("Choice of Decision Maker") cannot be a witness.
- ▶ A physician or mental health service provider who is treating you, or a relative of a person who is treating you. Your case manager, any doctor who is treating you while you are in the hospital, your counselor or private psychiatrist cannot serve as witnesses.
- ▶ The owner or operator of the facility where you live, or a relative of one of these people. For example, if you live in a group home, the owner or staff of the group home cannot serve as witnesses. The same is true of staff at nursing homes, foster homes, board and care homes, etc.
- ▶ A person related to you by blood, marriage or adoption.

When the witnesses sign the form they acknowledge that:

- (1) you signed the **Declaration**;
- (2) *they believe you were mentally competent at the time you signed the form*; and
- (3) *they believe that you were not under duress, fraud or undue influence at the time you signed the form.*

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## ***Step 7 - Others' Signatures***

If you have a “Representative”, then make sure that your “Representative” has signed and dated the acceptance of appointment on page 7. Likewise if you have an alternate “Representative”, make sure that your alternate “Representative” has signed and dated the acceptance of appointment on page 7.

## ***Step 8 - Hand Out Copies***

Make sure that you give copies of the completed form to any doctor, provider, or facility from which you expect to need treatment. If you have appointed a representative, make sure that this person also has a copy. Your instructions cannot be followed if they are not known to exist.

# 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 be 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 am 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.







## ***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:

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

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[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.

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[Signature of Representative (Printed name) and Date]

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[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:**

Addictions and Mental Health Division  
500 Summer Street NE, E-86  
Salem, Oregon 97301-1118  
503-945-5763

NAMI-Oregon  
4701 SE 24th Street, Suite E  
Portland, Oregon 97202  
503-230-8009 or 1-800-343-6264

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

**We suggest you fill out this card and put it in your wallet.**

|  |       |
|--|-------|
| <b>Emergency Medical Information</b>   |       |
| Name: _____  |       |
| I have written a <b>Declaration for Mental Health Treatment</b> which is on file at: |       |
| _____  |       |
| <b>Immediately</b> contact my Representative at:                                     |       |
| _____  | _____ |
| Name   | Phone |
| or Alternate Representative at:  |       |
| _____  | _____ |
| Name   | Phone |

State of Oregon  
Oregon Health Authority  
Health Services  
Addictions and Mental Health Division

***State of Oregon***  
***Declaration for Mental Health Treatment***

Dated \_\_\_\_\_



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