DECLARATION FOR MENTAL HEALTH TREATMENT

Department of
Mental Health &
Substance Abuse Services

www.tn.gov/behavioral-health

This form was developed based on Tennessee Code Annotated, Title 33, Chapter 6, Part 10.

The DMHT in Tennessee

What Is a DMHT?

For those of us with mental illness, our commitment to recovery includes making a plan for keeping well. Many of us use the Wellness Recovery Action Plan (WRAP®) by Mary Ellen Copeland to list what we need to stay well, to identify our triggers, and to create a crisis plan. But there are times when, despite our commitment to recovery, we get worse. Perhaps something big happens in our lives and it's just more than we can cope with. Sometimes our symptoms get the better of us.

Tennessee has created a legal document that can help. It's called a Declaration for Mental Health Treatment (DMHT). And when we find ourselves in a crisis, it can give us peace of mind. The DMHT is a legal document where we can write down our wishes in case of a mental health crisis. We can write down mental health treatments and medications that are okay with us and any that are not okay with us. We can write down what it looks like when we are in a mental health crisis and need help. Some people like to write down which hospitals they prefer and which mental health agencies they prefer, too.

Here's how to fill out your DMHT:

1. Read the entire DMHT form first.
2. Some sections of the DMHT form ask you to choose at least one option. In those sections, you will have to pick one of the options.
3. When you write down your wishes on the form, be as specific as you can.
4. There is a place at the bottom of each page where you need to put your initials and the date.
5. When you are ready to sign, get two adults to be your witnesses.
6. Pick two people who already know you. You cannot pick anyone who works for a mental health facility. That's against the rules for the DMHT because the people who wrote the DMHT rules want to make sure you aren't pressured to write down anything you don't want to.
7. Before you sign in front of the witnesses that you picked, tell them about what you wrote in your DMHT.
8. Be sure to talk with the friends and family members of your choice about what you wrote in your DMHT so they can be there for you in the way you want.

Important Legal Information

The Tennessee Department of Mental Health and Substance Abuse Services developed this form based on Tennessee Code Annotated, Title 33, Chapter 6, Part 10.

Tennessee Code Annotated, Title 33, Chapter 6, Part 10, gives the right to individuals, 16 years of age and older, to be involved in decisions about their mental health treatment. The law also recognizes that, at times, some individuals are unable to make treatment decisions. A "Declaration for Mental Health Treatment" allows people receiving services to plan ahead; it may also assist service providers in giving appropriate treatment.

This "Declaration for Mental Health Treatment" form describes what a service participant wants to occur when receiving mental health treatment. It describes mental health services that a service participant might consider, the conditions under which a declaration may be acted upon, and directions on how a service participant can revoke/cancel a declaration.

For example, completion of a "Declaration for Mental Health Treatment" form allows a service participant to state:

- Conditions or symptoms that might cause the declaration to be acted upon;
- Medications you are willing to take and medications you are not willing to take;
- Specific instructions for or against electroconvulsive or other convulsive treatment;
- Mental health facilities and mental health providers which you prefer;
- Treatments or actions which you will allow or those which you refuse to permit; and
- Any other matter pertaining to your mental health treatment which you wish to make known.

You must sign the form in front of two (2) competent adult witnesses (18 years or older) who know you. You must discuss the contents of this form with the witnesses prior to them signing it. It is important to note that restrictions exist on who may witness the declaration. The following parties may <u>not</u> act as witnesses:

- o The service participant's mental health service provider;
- o An employee of the service participant's mental health service provider;
- o The operator of a mental health facility; or
- o An employee of a mental health facility.

This declaration may include consent to, or refusal to, permit mental health treatment and other instructions and information for mental health service providers.

Declaration for Mental Health Treatment for:

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(Print Your Full Name)

This DMHT says what my wishes are for mental health treatment when I am in a mental health crisis and can't make decisions for myself.

I understand that sometimes I cannot make decisions about mental health treatment because of the symptoms of my mental illness. This is when I am in a mental health crisis.

Here are my symptoms when I am having a mental health crisis:

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Initials____Date__________

This DMHT gives me the right to say what medications I am okay with, how I feel about ECT (electroconvulsive therapy), and which psychiatric hospital I prefer (for up to 15 days).

Medication *(Psychoactive and other Medications)*

If I am in a mental health crisis and cannot make my own mental health treatment decisions, here are my wishes about medication:

You must check one:

☐ I do not have a preference about medications.

☐ I do not want the following medications:

Name of medication: ______________________________

Reason I don't want it: ______________________________

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Name of medication: ______________________________

Reason I don't want it: ______________________________

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Name of medication: ______________________________

Reason I don't want it: ______________________________

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Name of medication: ______________________________

Reason I don't want it: ______________________________

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Initials____Date__________

These medications have worked for me in the past:

Name of medication: ____________________

How it worked for me: ____________________

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Name of medication: ____________________

How it worked for me: ____________________

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Name of medication: ____________________

How it worked for me: ____________________

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Additional medication concerns:

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Initials____Date__________

Going to the Hospital

*(Admission to and Remaining in a Hospital for Mental Health Treatment)**

If I am in a mental health crisis and not able to make decisions, these are my preferences about going to the hospital:

You must check one:

- ☐ I do not have a preference about being admitted to a hospital for mental health treatment.
- ☐ I am okay with being admitted to a hospital for mental health treatment. I consent.
- ☐ I do not want to go voluntarily to a hospital for mental health treatment. I do not consent.

If I have to go to a hospital for mental health treatment, then I want the following to happen:

You must check one:

- ☐ I will remain voluntarily in the hospital for mental health treatment. I consent.
- ☐ I do not want to remain voluntarily in the hospital for mental health treatment. I do not consent.

Additional hospitalization concerns:

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*Psychiatric hospital authorization in a DMHT is limited to 15 days.

Initials____Date__________

Mental Health Services from Other Places

Tennessee has places other than the hospital where you can receive help for your mental illness. These are places like a Crisis Stabilization Unit (CSU), a respite facility, and others.

If I am in a mental health crisis and not able to make decisions, these are my preferences about receiving mental health services from places other than a hospital:

You must check one:

☐ I do not have a preference about receiving mental health services from places other than a hospital.

☐ I am okay with receiving mental health services from places other than a hospital. I consent.

☐ I do not want to receive mental health services from places other than a hospital. I do not consent.

Additional concerns about mental health services from other places:

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Initials____Date__________

Specific Mental Health Agencies, Hospitals, and Other Places for Treatment

If I am in a mental health crisis and not able to make decisions, these are my preferences about certain mental health agencies, specific hospitals, and other places for mental health treatment:

Check all that apply:

☐ I do not have a preference about any specific mental health agencies, specific hospitals, and other places for mental health treatment.

☐ I do not prefer the following specific mental health agencies, specific hospitals, and other places for mental health treatment.

☐ I do prefer the following specific mental health agencies, specific hospitals, and other places for mental health treatment.

Names of hospitals, mental health agencies, and other places for mental health treatment that I...	
DO NOT CONSENT TO:	**PREFER:**

Additional concerns about specific mental health agencies, hospitals and other places for treatment:

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Initials____Date__________

ECT (Electroconvulsive Therapy) and Other Convulsive Therapies*

If I am in a mental health crisis and not able to make decisions, these are my preferences about receiving ECT (electroconvulsive therapy) and other convulsive therapies:

You must check one:

☐ I do not have a preference about receiving ECT (electroconvulsive therapy) and other convulsive therapies.

☐ I do not want to receive ECT (electroconvulsive therapy) or other convulsive therapies. I do not consent.

☐ I am okay with ECT (electroconvulsive therapy). If I have any conditions, I have written them below.

☐ I am okay with other convulsive therapies. If I have any conditions, I have written them below.

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**Your decision to consent to electroconvulsive therapy may be limited if you are considered to be a child under certain provisions of the law. Your decision to consent to electroconvulsive therapy may be limited if you are a child in the state's custody under certain provisions of the law.*

Initials____Date__________

Other Preferences

If I am in a mental health crisis and not able to make decisions, here are some additional things I prefer:

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Here are the people I want to be called if I am in a mental health crisis:

Name ______________________________

Home Phone (with area code) ______________________________

Work Phone (with area code) ______________________________

Cell Phone (with area code) ______________________________

Name ______________________________

Home Phone (with area code) ______________________________

Work Phone (with area code) ______________________________

Cell Phone (with area code) ______________________________

Name ______________________________

Home Phone (with area code) ______________________________

Work Phone (with area code) ______________________________

Cell Phone (with area code) ______________________________

Initials____Date__________

My Affirmation

I am sixteen (16) years of age or older. I am capable of making informed mental health treatment decisions. I make this “Declaration for Mental Health Treatment” to be followed if I become unable to make informed mental health treatment decisions. The determination that I am unable to make an informed decision about my mental health treatment must be made by (1) a court in a conservatorship or guardianship preceding, or (2) two examining physicians, or (3) a physician with expertise in psychiatry and a doctoral level psychologist with health service provider designation.

I know that I may cancel this DMHT, in whole or in part, at any time, by word or in writing, when I am able to make informed treatment decisions.

This declaration will expire two years from the day it is signed by me and two witnesses or a shorter period specified by this date: ______/_______/______ or until revoked.

My Name (printed) ____

My Signature ______________________________ Date ________________

Address ____

City, State, ZIP ____

Phone (with area code) ____

Date of Birth ____

Initials____Date__________

Affirmation of the First Witness

I affirm that ____ is personally known to me; that he or she signed this "Declaration for Mental Health Treatment" in my presence; that he or she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He or she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:

The service participant's mental health services provider
An employee of the service participant's mental health services provider
The operator of a mental health facility
An employee of a mental health facility.

You must check one:

I am a relative by blood, marriage, or adoption.*

☐ Yes ☐ No

You must check one:

I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

☐ Yes ☐ No

First Witness Name (print) ____

First Witness Signature ______________________________ Date ________________

Address ____

Phone (with area code) ____

*Only one of the two witnesses can be a relative by blood, marriage, or adoption.
**Only one of the two witnesses can be a person likely to benefit from the death of the person completing the declaration.

Initials____Date__________

Affirmation of the Second Witness

I affirm that ____ is personally known to me; that he or she signed this “Declaration for Mental Health Treatment” in my presence; that he or she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He or she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:

The service participant’s mental health services provider
An employee of the service participant’s mental health services provider
The operator of a mental health facility
An employee of a mental health facility.

You must check one:

I am a relative by blood, marriage, or adoption.*

☐ Yes ☐ No

You must check one:

I am likely to be entitled to a portion of this person’s estate in the event of his/her death.**

☐ Yes ☐ No

Second Witness Name (print) ____

Second Witness Signature ______________________________________ Date ________________

Address ____

Phone (with area code) ____

*Only one of the two witnesses can be a relative by blood, marriage, or adoption.
**Only one of the two witnesses can be a person likely to benefit from the death of the person completing the declaration.

Initials____Date__________

Frequently Asked Questions

What is a Declaration for Mental Health Treatment?

A Declaration for Mental Health Treatment (DMHT) is a legal document where you can write down your wishes in case of a mental health crisis. You can write down mental health treatments and medications that are okay with you and any that are not okay with you. You can write down what it looks like when you are in a mental health crisis and need help. Some people like to write down which hospitals they prefer and which mental health agencies they prefer, too.

Who can make a DMHT?

Anyone sixteen (16) years of age or older, or an emancipated minor with capacity to make informed mental health treatment decisions.

Can you be required to fill out a DMHT?

No. Tennessee law specifically states that you cannot be required to complete a DMHT. In particular, a mental health service provider or a health insurance plan cannot require you to complete a DMHT in order to access services.

When may a DMHT be used?

A DMHT is used when you are unable to make informed decisions about treatment due to a mental illness. Note: A DMHT is only in effect when you are unable to make informed mental health treatment decisions.

What are the advantages of having a DMHT?

A DMHT allows you to plan and guide your mental health treatment according to your stated wishes if you later become unable to make informed decisions about your mental health treatment.

What areas of treatment can be covered by a DMHT?

A DMHT allows you to state which mental health treatments are, or are not, okay with you. You can make your wishes known about three types of mental health treatment:

1. Medications
2. Electroconvulsive and other convulsive therapies
3. Psychiatric hospitalization (for up to fifteen (15) days)

Who can help you fill out the form?

Anyone can help you complete the form. Many community mental health organizations have peer staff members who may be able to help you. Remember: A DMHT cannot be signed on the premises of a mental health service provider because the people who wrote the DMHT rules want to make sure you aren't pressured to write down anything you don't want to.

Who can I choose to be my witnesses to my DMHT?

Pick two adults who already know you. You cannot pick anyone who works for a mental health facility because the people who wrote the DMHT rules want to make sure you aren't pressured to write down anything you don't want to. At least one of the witnesses cannot be related to you by blood, marriage or adoption, or be someone who, at the time of signing, would benefit from your will or be entitled to any portion of your estate in the event of your death.

How can I make sure that the people who provide my mental health treatment know about my wishes?

You should give a copy of your completed DMHT to your mental health service provider and anyone who may help you when you are not able to make informed mental health decisions. You may want to give a copy to your medical doctor. You should discuss your DMHT with these individuals and keep a copy for yourself. Note: Many insurance providers are willing to keep a copy of your DMHT on file for you so that if you do have to be hospitalized, the insurance provider can send a copy of your DMHT to the hospital.

How can I change my DMHT?

If you are able to make informed mental health treatment decisions, you may change your DMHT at any time. You can make these changes verbally or in writing. You may also cancel an old DMHT and create a new one. It is important to give a copy of the new DMHT to the same people you gave your previous declaration. You should also give a copy to your service provider.

What happens if a court appoints a conservator?

If a court appoints a conservator to make mental health treatment decisions for you, your DMHT remains in effect and overrides the conservator with respect to mental health treatment covered under the DMHT.

What is the responsibility of the physician or other mental health service provider?

The physician or other mental health service provider must assess your capacity to make informed decisions about your treatment. Generally, the physician or other service provider will follow the DMHT only when you lack the capacity to make informed mental health treatment decisions.

Can a physician or other mental health service provider choose not to follow my DMHT?

Yes. If there is an emergency that places your health or life in danger, or if the mental health service provider, as a matter of conscience, cannot follow your DMHT, then they can legally choose not to follow your DMHT. In addition, if you are hospitalized against your will, your DMHT may not be followed. If this occurs, a Treatment Review Committee must review the proposal to not follow your DMHT so that it is not only one doctor or mental health professional making that decision.

Does a DMHT affect your insurance benefits?

No. A DMHT is not related to insurance benefits or payment for services. When completing a DMHT, you should consider the limitations of your insurance benefits. For example, if you request a service provider that is not approved by your insurance provider, you may have to pay for that service out of your own pocket.

Does a DMHT need to be notarized?

No. The DMHT does not need to be notarized.

Where can I find another copy of the DMHT form?

A DMHT form is available at the Tennessee Department of Mental Health and Substance Abuse Services website: http://tn.gov/mental/legalCounsel/olc.html. This form is also available from the TDMHSAS Office of Consumer Affairs and Peer Recovery Services by calling toll-free 1-800-560-5767.

Definitions

Electroconvulsive or other convulsive therapies: Treatments for depression that use electric shock or chemical agents to induce mild seizures. Electroconvulsive therapy is sometimes called ECT or “shock therapy”.

Informed Mental Health Treatment Decision: A decision made by a person with mental illness who has the ability to understand the proposed procedures, their risks and benefits, and the available alternative procedures.

Mental Health Service Provider: An agency or a person who provides mental health services and supports.

Mental Health Facility: An agency or facility licensed to provide mental health services and supports.

Psychoactive Medication: A drug that acts directly on the central nervous system to influence consciousness, mood, and awareness.

Revoke: To withdraw, cancel, or take back.

Service Participant: A person who is receiving services, has applied for services, or for whom someone has applied for or proposed services because the person has mental illness or serious emotional disturbance. Service participants can be called consumers, clients, or patients.

For additional information about the
Declaration for Mental HealthTreatment, contact the
Tennessee Department of Mental Health and Substance Abuse Services
Office of Consumer Affairs and Peer Recovery Services
at (800) 560-5767
or by email to
OCA.TDMHSAS@TN.GOV

For questions about information on the www.tn.gov/behavioral-health
website, contact the Publication Editor c/o the
Tennessee Department of Mental Health and Substance Abuse Services at
(800) 560-5767
or by email to
OC.TDMHSAS@TN.GOV
Visit: tn.gov/behavioral-health/declaration-for-mental-health-treatment

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The Tennessee Department of Mental Health and Substance Abuse Services is committed to the principles of equal opportunity, equal access and affirmative action. Contact the TDMHSAS EEO/AA Coordinator at (615) 532-6580, Office of Human Resources; the Title VI Coordinator at (615) 532-6510; or the ADA Coordinator at (615) 532-6700 for further information. Persons with hearing impairments should contact the department by email at OC.TDMHSAS@TN.GOV