

DECLARATION FOR MENTAL HEALTH TREATMENT



**Tennessee Department of Mental Health
and Substance Abuse Services**

developed this form 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 not 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:

(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:

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: _____

Name of medication: _____

Reason I don't want it: _____

Name of medication: _____

Reason I don't want it: _____

Name of medication: _____

Reason I don't want it: _____

Initials _____ Date _____

These medications have worked for me in the past:

Name of medication: _____

How it worked for me: _____

Name of medication: _____

How it worked for me: _____

Name of medication: _____

How it worked for me: _____

Additional medication concerns:

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:

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 proceeding, 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 _____

For additional information about the
Declaration for Mental Health Treatment, contact the
TDMHSAS Office of Consumer Affairs and Peer Support Services
at 1-800-560-5767
or by email to
OCA.Tdmhsas@tn.gov

For questions about information on our Website,
Contact the Publication Editor c/o the
Tennessee Department of Mental Health and Substance Abuse Services
Office of Communications
at (615) 253-4812
or by email to OC.Tdmhsas@tn.gov



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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