Advance Directives

Mental Health Treatment Declaration

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"Advance Directives" is a general term used to describe different ways of documenting your healthcare wishes.

In Illinois, the four primary forms of Advance Directives are a living will (LW), a Mental Health Treatment Declaration (MHTD), the Illinois Department of Public Health Do Not Resuscitate (DNR)/ Practitioner Orders for Life-Sustaining Treatment (POLST) and a Power of Attorney for Health Care (PoAHC). It is important to understand the purpose of each form. You may fill out any or all of these forms depending on your personal goals. This booklet explains the Mental Health Treatment Declaration.

The Mental Health Treatment Declaration

The Illinois Mental Health Treatment Declaration enables an adult of sound mind to declare in advance their preferences or instructions for mental health treatment should they become unable to make decisions (incapacitated due to mental illness) and to identify someone as an alternate decision-maker (called an "Attorney-In-Fact") during this period.

What is the Declaration?

The Mental Health Treatment Declaration allows you to accept or refuse mental health treatment based upon your wishes while of sound mind, and to name an individual to speak for you (the "Attorney-In-Fact"). The preferences expressed in the Declaration take precedence over preferences expressed while incapacitated due to the symptoms of a mental disorder. This allows you to specify in advance, for example, that you wish to receive mental health treatment, even if you would refuse such treatment while suffering from a mental disorder; or, to refuse mental health treatment even if you would accept treatment while suffering from a mental disorder. For this reason, the Mental Health Treatment Declaration can only be revoked in writing, and only when you have been determined by a physician to be capable of making healthcare treatment decisions.

What treatments are covered?

You can make decisions in advance about three types of mental health treatment: electroconvulsive treatment (ECT), psychotropic medication and admission to and retention in a mental health treatment facility.

The Mental Health Treatment Declaration is good for three years. If you are incapacitated (unable to make mental health decisions) at the time the declaration is due to expire, it will remain in effect until you are able to make your own decisions.

Who can fill out a Declaration?

A Declaration can only be filled out by an adult (18 years old or older), and can only be filled out when the person is of sound mind, as confirmed by two witnesses.

When does the Declaration take effect?

The Declaration only becomes effective after two physicians have determined that you are unable to make decisions on your own behalf.

Who cannot witness a Mental Health Treatment Declaration?

- A person appointed as an Attorney-In-Fact by this document
- The principal's attending physician or mental health service provider or a relative of the physician or provider
- The owner, operator or relative of an owner or operator of a facility in which the principal is a patient or resident
- A person related to the principal by blood, marriage or adoption

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Declarant's name _____

Date of birth _____

Date _____

DECLARATION FOR MENTAL HEALTH TREATMENT

I,_____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by two physicians or the court that 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 electroconvulsive treatment, treatment of mental illness with psychotropic medication and admission to and retention in a healthcare facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

_____

_____

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

_____I consent to the administration of the following medications:

_____I consent to the administration of those medications recommended by my physician, and reviewed and approved by my Attorney-In-Fact under this document. This consent is limited by those medications I explicitly "do not consent to" in the section below.

_____I do not consent to the administration of the following medications:_____ _____

Conditions or limitations:_____ _____

_____

ELECTROCONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

_____I consent to the administration of electroconvulsive treatment.

_____I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: _____

_____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a healthcare facility for mental health treatment are as follows:

_____I consent to being admitted to a healthcare facility for mental health treatment.

_____I do not consent to being admitted to a healthcare facility for mental health treatment.

This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

Conditions or limitations: _____

_____

SELECTION OF PHYSICIAN (OPTIONAL)

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose Dr. _____ of _____

(Clinic name and/or address) (Telephone number)

to be one of the two physicians who will determine whether I am incapable. If that physician is unavailable, that physician's designee shall determine whether I am incapable.

ADDITIONAL REFERENCES OR INSTRUCTIONS

_____

Conditions or limitations: _____

ATTORNEY-IN-FACT

I hereby appoint:

Name _____ Relationship _____

Address _____

Telephone _____

(Home) (Work) (Other)

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

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 Attorney-In-Fact, I authorize the following person to act as my Attorney-In-Fact:

Name _____ Relationship _____

Address _____

Telephone _____

(Home) (Work) (Other)

My Attorney-In-Fact 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 Attorney-In-Fact. **If my wishes are not expressed and are not otherwise known by my Attorney-In-Fact, my Attorney-In-Fact is to act in what he or she believes to be my best interest.**

Signature of principal _____ Date _____

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is:

• A person appointed as an Attorney-In-Fact by this document • The principal's attending physician or mental health service provider or a relative of the physician or provider • The owner, operator or relative of an owner or operator of a facility in which the principal is a patient or resident • A person related to the principal by blood, marriage or adoption

Witnessed by:

_____	_____	_____
Signature of witness	Printed name of witness	Date
_____	_____	_____
Signature of witness	Printed name of witness	Date

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as Attorney-In-Fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or two physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

_____	_____	_____
Signature of Attorney-In-Fact	Printed name of Attorney-In-Fact	Date
_____	_____	_____
Signature of alternate Attorney-In-Fact	Printed name of alternate Attorney-In-Fact	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 three types of mental health treatment: psychotropic medication, electroconvulsive therapy and short-term (up to 17 days) admission to a treatment facility. The instructions you include in this declaration will be followed only if two physicians or the court believes you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

You may also appoint a person as your Attorney-In-Fact to make these 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 your desires are not stated or otherwise made known to the Attorney-In-Fact, to act in a manner consistent with what the person in good faith believes to be in your best interest. 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 Attorney-In-Fact at any time.

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 been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective when it is communicated to your attending physician in writing and is signed by you and a physician.
The revocation may be in a form similar to the following:

REVOCATION

I,_____, willfully and voluntarily revoke my declaration for mental health treatment as indicated

☐ I revoke my entire declaration. ☐ I revoke the following portion of my declaration.

_____

_____

_____

Date _____ Signed _____
Signature of principal

I, Dr. _____, have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

Date _____ Signed _____
Signature of physician

If there is anything in this document that you do not understand, you may contact the Clinical Ethics Center at 217–757–2353 for help or ask an attorney. 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.

NOTES

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