Montana Mental Health Care Advance Directive

Disclaimer:

This form was created by Disability Rights Montana, based on the mental health care advance directives law, Title 53, Part 13, of the Montana Code Annotated (2015).

This law says any signed, dated and notarized document that expresses a person's clear intention that it serve as a mental health care Advance Directive is valid in Montana. There is no "official" mental health care advance directive form, and no person may required to use any particular form for creating a directive. Advance Directives may be entirely handwritten and out-of-state Advance Directives are valid if they meet Montana's legal requirements.

We have produced this form for the use of any person who wants to create an advance directive. Copies of this form and other information about mental health care advance directives are available from Disability Rights Montana.

This *Mental Health Care Advance Directive* form and associated documents and instructions are not legal advice, nor are they a substitute for consultation with an attorney.

This form is revised from time to time. We welcome your questions, comments, criticisms and suggestions. Please contact us at 800-245-4743 or 406-449-2344 or click the "contact" link at http://disabilityrightsmt.org.

MONTANA
MENTAL HEALTH CARE
ADVANCE DIRECTIVE

I, _____, with capacity, do knowingly and voluntarily execute this Montana Mental Health Care Advance Directive on this _____ day of _____, 20_____.

To the extent that this document includes private health care information I hereby waive my privacy thereto for the purposes herein only, and specifically release my medical information to those providers listed in this document.

Section 1. Period of validity of this directive. (Choose one option below by initialing).

_____ This directive is valid indefinitely, or until I execute a later advance directive for mental health care.

_____ This directive is valid for _____ days after the date of signature.

_____ This directive is valid until the _____ day of _____, 20____ .

Section 2. Appointment of agent for mental health care decision-making. (Choose at least one option below by initialing).

_____ I choose not to designate an agent to express my mental health care decisions for me when I lack the capacity to express those decisions myself. This Advance Directive provides sufficient consent, under Montana law, for services and treatments described in this directive without need of an agent's further consent.

_____ I designate an agent to express my health care decisions during a period when I lack capacity.

Name: _____

Mailing address: _____

Telephone numbers: _____

Email address: _____

Other information: _____

_____ I designate an alternate agent in case my primary agent becomes unavailable. The alternate agent is:

Name: _____

Mailing address: _____

Telephone numbers: _____

Email address: _____

Other instructions _____

Section 3. When this directive goes into effect.

This mental health care directive goes into effect only after the health care provider who is in charge of my care at the time determines that I have lost the capacity to consent to mental health treatment.

This directive, and the power exercised by any agent I have hereby appointed, is in effect only as long as I remain incapacitated.

This Advance Directive may be over-ridden by a District Judge if I am involuntarily committed by a civil or criminal court, but it may still provide valuable guidance to my providers and to the court during any period of commitment and it should be considered whenever decisions are being made about my medical care.

By creating this directive, I exercise a right to make decisions about my medical care that is protected under the Montana and United States Constitutions.

Section 4. My instructions regarding revocability

(Choose ONLY ONE option by initialing. The third option has been given special emphasis so that it gets careful consideration).

_____ After I have been found to lack capacity to make medical decisions, I may revoke all or part of this directive at any time, including the nomination of my agent, in writing, with my signature, or by personally informing the health care provider who is in charge of my care at the time of revocation.

_____ After I have been found to lack capacity, my directive is irrevocable for the following period of time: _____
(indicate a period of time)

_____ *I give up my right to revoke this directive for as long as I lack capacity* to make medical decisions.

____ I understand that this means that I am giving up the power to say "no," as long as I am incapacitated, to any mental health treatment that I consent to in this directive.

____ Nevertheless, it is my informed and voluntary decision that this directive shall be effective during any time that I am determined to lack capacity, even over my own protests.

Section 5. The determination of incapacity.

I understand that the health care provider who is primarily responsible for my care at the time may make the determination that I have lost the capacity to make health care decisions. (You may impose special conditions by initialing one or more options, below.)

_____ For the purpose of triggering this Advance Directive, a second health care provider must agree, after examining me, that I no longer have the capacity to make decisions about my need for treatment.

_____ I further direct that the second provider must be:

☐ a medical doctor
☐ a psychiatrist (a psychiatrist is a medical doctor with specialized training)

_____ In making a determination about my capacity, my health care provider(s) must consider the following information about me.

These are some of the ways that I behave, how I express myself and what I look like when I am experiencing a crisis in my mental illness and have lost the ability to make decisions about my need for treatment. This description is based on my own experience and deserves full consideration in the decision-making process.

_____

_____

_____

(attach additional pages as necessary)

Section 6. The powers and duties of my agent, if I have one.

My agent has the power to express my consent to mental health treatment when I have been found to lack the capacity.

My agent must follow the specific instructions in this directive. If my agent is asked to make decisions that are not addressed in this directive, then the decision must be based on how I would make the decision if I had the capacity. My agent must consider my own values and experience in making decisions, and may not substitute his or her own values and judgment about what would be best for me.

My agent can resign by giving me a written notice. If my agent resigns while this Advance Directive is in effect, my agent must give the written notice to my treating provider.

While I am incapacitated, my agent has a right to obtain my medical records and medical information about me, to the same extent that I have that right, except for the following limitations:

_____ My agent may not obtain the following medical records:

_____

_____

_____

Section 7. Consent to treatment.

Choose the treatment you consent to by initialing next to the statement. You may give additional instructions on a separate piece of paper attached to this form.

By signing your initials, you are making a medical decision and giving a medical provider permission to provide that care.

If you write instructions, be very clear whether the instructions express a preference or a restriction. For instance, "I would like Dr. Brown to be my therapist" expresses a preference. If Dr. Brown isn't available, you may be treated by a different therapist. But, "Only Dr. Brown can provide me with therapy" means that if Dr. Brown is unavailable, you won't receive therapy.

a. _____ I consent to treatment by any provider who is assigned to care for me, though I prefer to receive care from the following persons:

_____

_____

_____

b. _____ I do not consent to treatment by the following providers:

_____

_____

_____

_____

_____

c. _____ I consent to residential placement in a group home, therapeutic foster home, or other non-medical residential facility, with the following preferences or restrictions:

_____

_____

_____

_____

_____

d. Medication.

(i)_____ I consent to medications as prescribed by my treating provider. My preferences, which are intended as guidance to my treating provider, are:

_____

_____

_____

_____

_____

(ii)_____ I consent ONLY to the following medication or medications, if prescribed: *(You can include explanations for your choices.)*

_____

_____

_____

_____

_____

(iii)_____ I do NOT consent to receive the following medication or medications: (You can include explanations for your choices.)

_____

_____

_____

_____

_____

e. _____ I consent to electro-convulsive therapy (ECT). My consent is limited as follows:

_____ I consent to a maximum number of _____ ECT treatments.

_____ I consent to ECT treatment only by the following provider(s):

_____

_____

My consent to ECT treatment is also limited by the following instructions:

_____

_____

_____

- OR -

_____ I DO NOT consent to electro-convulsive therapy (ECT) under any circumstances.

f. _____ I consent to hospitalization and treatment in a hospital or a secure treatment facility is limited to the following facilities.

_____

_____

_____

(i) ___ My consent includes voluntary admission to the Montana State Hospital.

(ii) ___ My consent to hospitalization or treatment in a secure facility is limited to no more than _____ days or_____ weeks.

Section 8. Preferences and special instructions for emergency interventions.

I understand that restraint, seclusion and other forms of physical intervention are not treatment. However, they may be permitted by law in emergency situations to prevent me from harming myself or others. Below, I have provided information about my personal experience with emergency situations, my preferences for how I am treated in an emergency, and special instructions to my health care providers.

My trauma history. These traumatic experiences have shaped how I respond to events:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

De-escalating a potential crisis. These medical and non-medical interventions help me to feel safe, trust my providers, and regain control of my thoughts and behaviors:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Restraint, and involuntary administration of medication. If some form of physical or medical emergency intervention is necessary to ensure my safety or the safety of other people, please consider my personal history, my experience with these interventions, and my preferences, as follows:

_____

_____

_____

_____

_____

_____

_____

_____

Section 9. Other medical conditions.

At the time that I completed this directive, I was receiving medical treatment for the following conditions:

_____

_____

_____

_____

_____

Section 10. Attachments.

I have attached additional information to this Advance Directive for mental health care. The following documents are part of this directive:

_____

_____

_____

_____

Section 11. My duty to provide a copy of my directive.

My provider must ask if I have an Advance Directive and must include a copy of the directive in my file, if it is provided. It is my responsibility to share my directive with providers, agents and others so that it is available in a crisis.

Section 12. Liability

Photocopies of this document can be relied upon as though they were originals.

It is my intent no one involved in my care shall be liable for honoring this directive or following the directions of my agent.

I understand that my health care provider must comply with the terms of this Advance Directive as much as possible after I have been determined to lack capacity to make health care decisions. However, I understand that this directive cannot obligate anyone to pay for services rendered to me, nor obligate anyone to provide me with services that are outside their normal scope of service.

I also understand that my provider does not have to provide me with any treatment that is not reasonably available, that would violate the accepted standard of care, or that would conflict with a law or a court order. My provider is not required to follow my directive in an emergency situation if it would endanger my life or health.

Section 13. Signature by the principal, optional signature by agent(s), and notarization requirement.

This document must be signed by the principal in the presence of a Notary Public for the State of Montana. Two signature lines have been provided for the agent and alternate agent, but agent signatures are not required.

_____ _____
Signature of principal Date

_____
Printed name of principal

_____
Address of principal

Subscribed and sworn to before me this _____ day of _____, 20____.

_____
Notary Public for the State of Montana

_____ _____
Signature of agent Date

_____ _____
Signature of alternate agent Date

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MENTAL HEALTH CARE ADVANCE DIRECTIVE
INSTRUCTION SHEET

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2. Please **PRINT** your name in the blank in line one, and today's date in the blank in lines two and three.

3. **Section 1:** involves the time period for which your **MENTAL HEALTH CARE ADVANCE DIRECTIVE** will cover. If you want it for an indefinite period, check the first line. Check the second box if you want your directive to be valid for only a period of days that you determine (by writing the number in the space provided). Check the third box if you want your directive to be valid until a certain date in the future (which you will determine in the space provided).

4. **Section 2:** involves the appointment of an agent (a person who acts on my behalf) to make mental health care decisions when you become unable to do so if desired. This is not required, but is an option. Check the first line if no agent is desired. Check in the space provided in the fifth line if you wish to appoint an agent, and provide the agent's name and contact information in the spaces provided.

   You may also wish to have an alternate agent as a back up plan in case the first agent is unable to perform as your agent. Check the space provided in the twelfth line if you wish to designate an alternate agent, and provide the alternate's agent's name and contact information in the spaces provided.

5. **Section 3:** describes the effectiveness of this document.

6. **Section 4:** lists my instructions about conditions under which this document can be revoked.
If I want to retain the unrestricted right to revoke this directive even though I have been found to lack capacity and may have an agent whom I appointed acting on my behalf, check the first line.

   If I wish for my directive to be irrevocable for a period of time following the determination that I lack capacity, check the space provided at line five, and fill the time period in the space provided.

   If I wish to give up my right to revoke this directive for any time that I lack capacity, check the space provided in the box provided in Section 4. at the bottom of page 2. There are two rights that go along with this right in the box that should be read and checked also.

7. **Section 5:** involves conditions on the determination of incapacity. It is not required to attach conditions to the determination of incapacity. One health care provider who is primarily responsible for my care can make the determination. However, it may be desirable to have more than one provider make the determination of incapacity.

   Check the space provided at line one if you want a second health care provider to agree, upon examination, to the determination of incapacity in order to trigger this directive.

   If you want to further determine whether that provider is a medical doctor or a psychiatrist, check the space provided at line 4 and the appropriate box as indicated. Also, if you want providers to take special circumstances into consideration in making the incapacity determination, check the space provided at line 7, and describe the circumstances in the spaces provided. Attach additional pages as necessary. (You must initial each additional page.)

8. **Section 6:** describes the powers of any agent or alternate agent that I may appoint. Agents under these circumstances would need access to medical records. However, you may limit the records your agent has access to by checking th space provided in line one on page 4 and describing the records in the spaces provided.

9. **Section 7:** details your instructions for your care and treatment and should be carefully thought out, and perhaps discussed with a loved one and/or a medical provider. If you will consent to treatment by any provider assigned to you, but wish to express a preference, check the space provided at 7.a., and write in your preferences in the space provided.

   If you do not want treatment by certain providers you may withhold your consent to treatment from those providers by checking the space provided at line 7.b. and writing in the name of the provider in the space provided.

If you consent to placement in a group home, foster home or facility, check the space in line 7.c. You may express preferences and restrictions here as well in the spaces provided.

10. **Section 7.d:** involves *medication*. If you wish to consent to those medications prescribed by your treating provider, check the space in line 7.d.(i.) On page 5. You may list your preferences which will help your provider.

    If you wish to consent to only certain medications, check the space provided at line 7.d.(ii), and list them in the spaces provided.

    If there are medications you wish to refuse, you may withhold your consent to those medications by checking the space provided at line 7.d.(iii), and listing the medications in the space provided.

11. **Section 7.e:** involves *electro-convulsive therapy (ECT).* Check the space provided in line 7.e if you wish to consent to ETC. If you don not wish to consent to ECT, check the space provided at the bottom of paragraph 7.e on page 6.

12. **Section 7.f:** involves *hospitalization.* Check the space in line 7.f in you wish to consent to hospitalization in a certain facility and designate the facility in the space provided. If your consent includes voluntary admission to the Montana State Hospital, check the box in line 7.f(i). If you wish to limit your consent to hospitalization to a number of days or weeks, check the space provided in line 7.f.(ii) and indicate the number of days or weeks in the spaces provided.

13. **Section 8:** allows you to list some of your preferences and instructions for emergency interventions that may be necessary. It is useful to list your experiences with *trauma* because it shapes how you respond to emergency events. Please do so in the spaces provided.

    You may instruct your providers on interventions that will help to de-escalate a potential crisis situation. Please do so in the spaces provided on page 7.

    Sometimes restraint or giving you medication without your consent is necessary to protect you and others from harm. Your personal experience with these interventions and your preferences is important to consider when providers need to use these interventions in the future. Please describe your history and preferences regarding restraint and involuntary administration of medication in the spaces provided on page 7.

14. **Section 9:** gives you the opportunity to list *other medical conditions.* Please list any other medical conditions you are experiencing in the spaces provided at the top of page 8.

15. **Section 10:** gives you the opportunity to attach any other documents to your **MENTAL HEALTH CARE ADVANCE DIRECTIVE** that you think are important to consider.

16. **Section 11:** describes your duty to provide a copy of your **MENTAL HEALTH CARE ADVANCE DIRECTIVE** to providers.

17. **Section 12:** deals with *liability*.

18. **Section 13:** is for *signatures*. Please sign in the space provided. You must have your signature notarized.

Registry with Montana Department of Justice, Consumer Protection Office
www.endoflife.mt.gov

1. Click on "How to file an Advance Directive."

2. Print and fill out the Consumer Registration Agreement.

3. Mail the agreement and your signed and notarized Mental Health Care Advance Directive to:

   End-of-Life Registry
   PO Box 201410
   Helena, MT 59620-1410