Montana Advanced Directive
For Mental Health Care

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I, _____, with capacity, do knowingly and voluntarily execute this advance directive for mental health care on this _____ day of_____, 20____.

To the extent that this document includes private health care information I hereby waive my privacy thereto for the purpose 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 by <u>initialing</u>).

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

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

_____ This directive is valid until this _____ 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 agent's further consent.

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

Name: _____

Mailing address: _____

Telephone number: _____

Email address: _____

Other information: _____

_____ I designate an alternative agent in case my primary agent becomes unavailable.

The alternate agent is:

Name: _____

Mailing address: _____

Telephone number: _____

Email address: _____

Other information: _____

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 herby 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 involuntary 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 Montana and the United States Constitution.

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 agents of in writing, with my signature, or my personally informing the health care provider who is in charge of my care at the time of recovery.

_____ 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.

OR:

_____ Nevertheless, it is my informed and voluntary decision that this directive during any time that I am determined to lack capacity, even over my own protest.

Section 5. The determination on 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 provider must be:

- A medical doctor
- A psychiatrist (A psychiatrist is a medical doctor with specialized training)

_____ In making the 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).

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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 capacity.

My agent must follow my specific instructions in this directive. If my agent is asked to make decisions that are not addressed in the 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 judgement about what would be best for me.

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

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

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:

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Section 7. Consent to treatment.

Choose the treatment you consent to by initializing 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.

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

_____

_____

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_____

b.____ I do not consent to treatment by the following provider(s):

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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:

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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:

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

_____

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(iii)_____ I do **NOT** consent to receive the following medication or medications:

(You can include explanations for your choices).

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

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

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

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_____ I **do not** consent to electro-convulsive therapy **(ECT)** under any circumstances.

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

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

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(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.

(Be as specific as you can in your instructions).

My trauma history.

These traumatic experiences have shaped how I respond to events:

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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:

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Section 9. Other medical conditions.

At the time I completed this directive, I was receiving medical treatment for the following condition(s):

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Section 10. Attachments. I have attached additional information to this Advanced 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 Advanced 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 that 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 of 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

_____ _____

Signature of agent Date

_____ _____

Signature of alternate agent Date

Subscribed and sworn to before me this day of _____, 2015

Notary Public for the State of Montana