EXHIBIT 3
DATE 4/6/11
HB 518

HB 518 mental health advance directives Sponsored by Rep. Hunter

The problem this bill addresses:
Mental illnesses are cyclical. Some people experience years and some only months between episodes of psychosis, mania or suicidality. In a full-blown crisis, the state can often intervene; judges commit people who are a danger to themselves or others. But crises are typically preceded by a period of decompensation and incapacity when everyone but the person with the illness can see what is happening, yet there is no legal way to break through the denial and get treatment. HB 518 creates a legal mechanism for the consumer to consent–in advance–to care during these periods of incapacity.

Who can create a directive:
Adults and children who are at least 16, because they have a statutory right to consent to mental health services (see §53-21-112, MCA).

What triggers a directive:
A supervising healthcare provider's determination of "incapacity."

A supervising healthcare provider is not necessarily a doctor.
In smaller communities, this can be an advance practice nurse or a mental health professional. Also, as the situation changes, the supervising provider may change, too.

The principal can include a personal definition of "incapacity" in the directive.
A person may able to do advanced math but have temporarily lost the ability to understand the significant benefits of getting treatment for mental illness. HB 518 requires the supervising healthcare provider to take into consideration the principal's description of "incapacity" in making the determination.

Kinds of care a directive can consent to:
Anything connected to mental health treatment, including medications for other medical conditions that can have an effect on the mental illness. Metabolic disorders, kidney, liver and heart disease are side-effects of the medications that are used to treat mental illness. Most people with mental illness are also being treated for other health conditions.

Why a directive can provide consent to hospitalization:
Consumers asked for this. St. Pat's, the Billings Clinic and Kalispell Regional believe this could be a useful tool. Brief hospitals stays are often sufficient to resolve a crisis so that a person can return to a lower level of care in the community

A bad mental health directive is like having no mental health directive: the patient is neither in a worse nor a better position as a result.
The only reason to create the directive authorized by HB 518 is to provide consent to treatment that is medically appropriate under the prevailing standard of care. Patients don't need directives to refuse care–they've always had that right. They need directives so they can consent to care during periods of incapacity.

Why it's a good idea to have a mental health directive that's legally sufficient on its own.
Mental illness complicates relationships. It may be difficult to trust anyone or there may not be any responsible adults left in a person's life. Requiring that everyone designate an agent will discourage creation of directives.

What the proposed advance directive law does not change:

The right of a provider to refuse treatment
The right of a patient to receive treatment
The medical standard of care
Hospital admission policies
Insurance policies, Medicaid or Medicare policies

A directive also does not:

Apply at the State Hospital, prison or jail.
Change civil commitment, guardianship or criminal law.
Limit court authority in any way.

A directive can be challenged:
HB 518 gives judges the authority to review advance directives.

Why a directive, including an agent, may survive a guardianship order:
A judge in a guardianship proceeding must be given a copy of the directive and has the power to revoke or amend the directive by order. But if, for some reason, there is both a guardian and a directive, then HB 518 says the mental health care provider should follow the directive. The reason: The directive was created when the person had the capacity to exercise a constitutionally protected right to make healthcare decisions. Also, guardianships are usually broad, general and long duration, while mental health advance directives are limited in scope, specific to a particular medical situation, and their application is limited in duration.

Why the principal can choose whether to make the directive revocable or irrevocable.
The Montana living will and durable power of attorney are both revocable at any time, even after a patient has lost capacity. The workgroup that debated this issue at DRM last spring unanimously recommended allowing the principal to choose whether to make the mental health directive irrevocable. The group hoped that this would encourage more people to create directives and learn how they work.

Why this bill is good public policy:
One of the highlights of the 2009 legislature was passage of the three "mental health crisis bills" that promote the development of prompt, intensive, local mental health interventions. Like the crisis bills, HB 518 promotes prompt, cost-effective, community care and prevent expensive legal proceedings and commitment to the State Hospital.

Montana is moving towards a "recovery" model of mental health care, which emphasizes the self-determination of people with live with mental illness but also requires that patients take responsibility for managing those illnesses. Advance directives are a potentially valuable tool for achieving recovery.

Anita Roessmann, Disability Rights Montana, 406-461-5350 (cell)

Montana Code Annotated 2009

53-21-153. Mental health advance directive authorized -- content -- cause of action created -- definitions. (1) An individual 18 years of age or older with mental capacity may voluntarily execute a mental health advance directive providing that if the individual is treated for a mental disorder at an inpatient facility, the directions concerning who must be notified and who may visit the individual, as provided in this section, are to be followed. An inpatient facility that is furnished a copy of a mental health advance directive shall comply with the directive and shall make the directive a part of the individual's medical record.

(2) The directive may address any combination of the following subjects:

(a) who should be notified promptly in the event of the individual's admission to or treatment at the facility;

(b) who should or should not be allowed to visit the individual at the facility; and

(c) the duration of the directive.

(3) The directive authorized in subsection (1) must be in writing and must contain:

(a) a statement that the individual has the mental capacity to execute the directive and that the directive is executed voluntarily;

(b) a statement that once signed, a directive of which the facility is furnished a copy takes effect upon the determination of the lack of mental capacity by the treating mental health professional of the individual and remains in effect until:

(i) revoked by the individual, orally or in writing, at a time that the individual has the mental capacity to revoke the advance directive, as determined by the treating mental health professional;

(ii) the directive expires by its own terms; or

(iii) the individual dies;

(c) the signature of the individual; and

(d) the signature of two witnesses.

(4) (a) An individual may revoke a mental health advance directive provided that the mental health professional chosen by or provided for the individual determines in good faith that the individual has sufficient mental capacity to revoke the directive. The inpatient facility shall make a valid revocation a part of the individual's medical record.

(b) An advance directive is valid and enforceable only with respect to the matters provided for in subsection (2) even if the directive addresses subjects in addition to those provided for in this section.

(5) If an inpatient facility fails to act in accordance with a mental health advance directive of which the facility was furnished a copy, an individual who has executed the mental health advance directive or who has the right to be notified or to visit the individual at the facility pursuant to a mental health advance directive has a cause of action against the facility for injunctive relief and reasonable costs and attorney fees incurred in bringing the action.

(6) As used in this section, the following definitions apply:

(a) "Advance directive" or "directive" means a writing complying with the requirements of this section.

(b) "Inpatient facility" or "facility" means a health care facility that provides emergency, crisis, or acute care to a person with a mental disorder.

(c) (i) "Lack of mental capacity" means that an individual does not have sufficient ability to make or communicate decisions regarding a need for treatment.

(ii) The lack of mental capacity does not require that a person be legally determined to be an

incapacitated person, as defined in 72-5-101. However, a person who is under a current legal determination of being an incapacitated person has a lack of mental capacity.

(d) "Mental capacity" means sufficient ability to make or communicate decisions regarding a need for treatment.

History: En. Sec. 1, Ch. 533, L. 2001.

Provided by Montana Legislative Services

Psychiatric Advance Directives: Pros, Cons, and Next Steps...

Since 1991's passage of the Federal Patient Self-Determination Act, Advance Directives (ADs) have been used as a tool to increase patient and family involvement in future health care planning. This trend spurred a similar movement in mental health care, which resulted in the creation of **Psychiatric Advance Directives** (or **PADs**). PADs are tools to enhance the mental health consumer's* "voice" in his or her treatment.

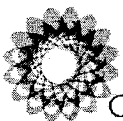
The National Resource Center on Psychiatric Advance Directives defines PADs as legal instruments that document a competent person's specific instructions or preferences regarding future mental health treatment. The intent is to facilitate timely access to care during acute psychiatric episodes when an individual loses the ability to give or withhold informed consent to treatment. A growing body of literature provides information on what PADs are, how they are used, and strategies for more effective implementation, including model laws and toolkits.

The purpose of this Fact Sheet is to offer some of the major pros and cons associated with PADs. Further, for those considering executing PADs – and for states considering PADs legislation– it offers tips, next steps and a list of tools, resources, and references to guide discussion around optimal implementation.

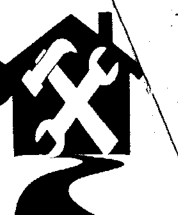
PROS - A Psychiatric Advance Directive has the potential to:

- Empower individual consumer's self-determination in decision-making, strengthening goals of consumer empowerment and "voice" in care;
- Increase satisfaction, motivation, and treatment adherence for better, more cost-effective outcomes;
- Enhance continuity of care, and promote early intervention and preventative care;
- Encourage treatment collaboration and communication between the consumer, family, and clinical team about treatment options, preferences, and self-care;
- Decrease reliance on coercive measures;
- Assist in crisis de-escalation; and
- Decrease hospitalization and costly court involvement.

* see Glossary



The UPenn Collaborative on Community Integration is A Rehabilitation Research & Training Center Promoting Community Integration of Individuals with Psychiatric Disabilities, funded by the National Institute on Disability and Rehabilitation Research.



Psychiatric Advance Directives: Pros, Cons, and Next Steps...

CONS - Potential Problems Associated with Psychiatric Advance Directives

- Insufficient education of consumers about the role of PADs, how to complete them, and their limits;
- Insufficient education of clinical staff and providers about PADs;
- Insufficient attention to logistical concerns, such as:
  - How to raise awareness among clinical staff and crisis providers as to existence of PADs
  - How to access them on 24/7 basis;
- Questions around legality and liability, especially when consumers use a PAD to:
  - Refuse treatment seen as critical in crisis
  - Be hospitalized even when hospitalization is objected to during the acute crisis (e.g. "voluntary commitment contract");
- Concerns over requests for treatments not viewed as within the "standard of care*" or best practices*, or treatments that are not available in the community (or unaffordable);
- Lack of clarity around ability to carry out or revoke a PAD;
- Uncertainty over who can/should be a health care agent*, especially for individuals without available (or willing) family/friends;
- Difficulty in predicting what treatments will be available and preferred in a "future" crisis;
- Stigmatizing to single out mental health consumers for distinct PADs (with related rules), as somehow "different" from those with cognitive impairments completing general health care Advance Directives.

It is worth noting that many of the concerns raised about PADs can also be raised about Advance Directives generally, and/or are of a more procedural versus substantive nature. Instead of the outright rejection of PADs, the key to their effective implementation seems to lie in better education, communication, and technical assistance.

* see Glossary

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Psychiatric Advance Directives: Pros, Cons, and Next Steps...

TIPS

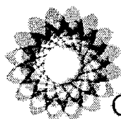
- Know the status of your state's law on PADs. For information about specific states, see: *http://www.nrc-pad.org/index.php?option=com_content&task=view&id=41&Itemid=25*

For Consumers:

- If no specific statutes exist, consider consulting mental health advocates and legislators to add language to promote and facilitate use of PADs for enhanced consumer participation and crisis de-escalation.
- If you choose to use a PAD:
  - Talk with peers, family, friends, and clinicians about your preferences
  - Revisit the document regularly so it's up-to-date with evidence-based practices* and your own preferences based on experience
  - Make sure your agent (if chosen) and clinicians know how to access it

For Service Providers and Advocates:

- The implementation or revision of AD or PAD statutes can be accomplished faster and better when:
  - All stakeholders are educated about advance directives. Stakeholders include: consumers and family members, clinical staff and administrators, legal/law enforcement personnel, policymakers, and payors)
  - Consumer education is enhanced through discussion and training, the use of peer support models, and access to software tools (e.g., AD-Maker)
  - The competency and capacity of the individual using the PAD has been adequately assessed.
- If implementing/revising AD or PAD statutes, address logistical and legal issues early on through education of and discussion among all key stakeholders.
- Help educate staff, administrators, policymakers, and the public about PADs and their value in enhancing consumer voice in treatment.
- In order to ensure that the use of PADs matches their promise, support is needed for research about the best ways to implement them as well as the development of methods that better assess an individual's capacity to make decisions.



Psychiatric Advance Directives: Pros, Cons, and Next Steps...

TOOLS

The Advocacy Center for Persons with Disabilities (PAD Toolkit):
http://www.advocacycenter.org/AdvanceDirectives/advancedirectives.htm

Bazelon Center for Mental Health Law (Template/Forms for completion, FAQs):
http://www.bazelon.org/issues/advancedirectives/index.htm

Mental Health America (*formerly* National Mental Health Association) Psychiatric Advance Directive Toolkit: *http://www1.nmha.org/position/advancedirectives/index.cfm*

Software: AD-Maker (designed to facilitate PAD execution through written information, voice-over prompts): See Sherman P: Computer-assisted creation of psychiatric advance directives. Community Mental Health Journal 34:351-362, 1998.

RESOURCES

Information

National Resource Center on Psychiatric Advance Directives: *http://www.nrc-pad.org/index.php*

National Disabilities Rights Network: *http://www.napas.org/issues/advdir/default.htm*

GLOSSARY (Terms used in this document)

Mental Health Consumers (Consumers) – people who have been diagnosed with a mental illness and who use mental health services. Consumers are also sometimes referred to as individuals with psychiatric disabilities, persons in recovery, and clients.

Mental Health Care Agent – a competent adult who is 18 years or older who you designate to make treatment decisions on your behalf in the event that you are unable to make competent decisions during a mental health crisis. Agents are also referred to as mental health power-of-attorney, attorney-in-fact, surrogate, or proxy decision-maker.

Evidence-Based Practices – specific clinical interventions or services for which there is consistent, scientific evidence showing that they produce benefits to consumers and their quality of life. Research in the field of mental health has shown that there is consistent scientific evidence that some specific practices work well in improving outcomes in the lives of individuals diagnosed with a severe mental illness.

Best Practices – strategies, interventions, or approaches that appear promising and are viewed as beneficial by policy makers, providers, and consumers.

Standard of Care - medical or psychological treatment guidelines that can be general or specific. They specify appropriate treatment protocols based on scientific evidence and collaboration between medical and/or psychological professionals involved in the treatment of an individual.

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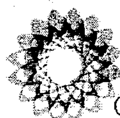
Srebnik DS, Russo J, Sage J, et al.: Interest in psychiatric advance directives among high users of crisis services and hospitalization. Psychiatric Services 54(7):981-986, 2003.

Srebnik D, Brodoff L: Implementing psychiatric advance directives: service provider issues and answers. Journal of Behavioral Health Services & Research 30(3):253-268, 2003.

<u>Case Law</u>

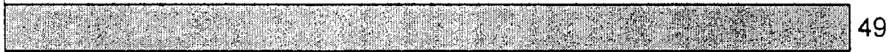
Hargrave v. Vermont, 340 F.3d 27 (2nd Cir. 2003) (enjoining enforcement of Vermont statute that allowed hospital to override mental health instructions in durable power of attorney after 45 days if no "significant clinical improvement" as discriminatory in violation of ADA)



Questions about psychiatric advance directives — Number of states where the answer is "Yes"

Does the state statute allow me to write separate legal advance instructions for my future mental health treatment?

Does the state statute allow me to appoint a healthcare agent to make at least some mental health treatment decisions for me?

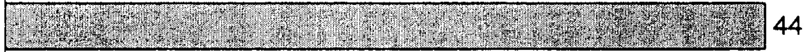


Can I write mental health advance instructions only on a form appointing a health care agent?

Does the state statute require that I have both an advance instruction (or "declaration") and a healthcare agent in order for my PAD to be legal?

Can I document advance preferences or consent for medications?

Can I document advance refusal of medications?



Can I document advance preferences or consent for hospitalization?

Can I document advance refusal of hospitalization?

Does the state statute require that a qualified mental health professional certify that I am competent to complete a PAD?

Does the state statute require that a qualified mental health professional pre-approve any of the content of my PAD, i.e., its appropriateness?

Does a court have to determine that I am legally incompetent in order for my PAD to go into effect during a crisis?