



My Rights, My Decisions Form Kit



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To SUBMIT your completed My Rights My Decisions Form Kit.

If your clinician works at Canberra Health Services, they should put your kit on their system.

If your clinician does not work at Canberra Health Services, email it to

TribunalLiaison@act.gov.au.

See back page for full instructions.

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ACT Mental Health Consumer Network Inc. is the owner of My Rights, *My Decisions*. People can use *My Rights, My Decisions* but must not change anything in it.

Consumers from the ACT Mental Health Consumer Network helped write the *My Rights, My Decisions Form Kit.* These organisations also helped:











MY RIGHTS, MY DECISIONS FORM KIT

This kit has information about your rights and decisions you can make.

You can use this kit to write down what you think and what you want.

If you get unwell in the future and can't make decisions, your clinicians will know what you want.

Important:

Sometimes, your clinicians may not agree with your decisions. In that case, they will make decisions for you. This can only happen if there is an emergency or if you are not safe and the ACT Civil and Administrative Tribunal agrees with the clinicians.

The *Mental Health Act 2015* (ACT) is an important document that talks about what happens when people have mental health issues. This is what you can do in these forms:

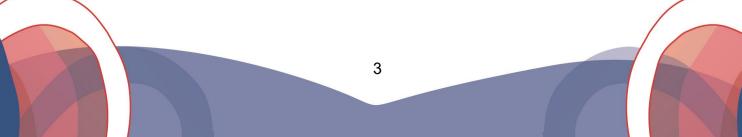
- **Nominated Person** in this form, you can choose a person to help you make decisions about your treatment and care. This may be a friend, a family member or another person you trust (See page 4).
- Advance Agreement this form will tell us what you want to happen if you ever become unwell and can't make your own decisions. For example, you can say what should happen to your family, pets and bills. You can write down other important information. For example, languages you speak or illnesses you have (See page 5). Note: To be discussed with and signed by your clinician.
- Advance Consent Direction in this form, you can agree to treatment and care in case you can't make your own decisions in the future. You can say what treatments or medicines you agree to or don't agree to. You can also explain who is allowed or not allowed to have information about you (See page 11). Note: To be discussed with and signed by your clinician.

Please talk about these forms with your clinician. You can fill in one or more parts of the form. You must be able to make your own decisions when you fill in these forms.

Privacy

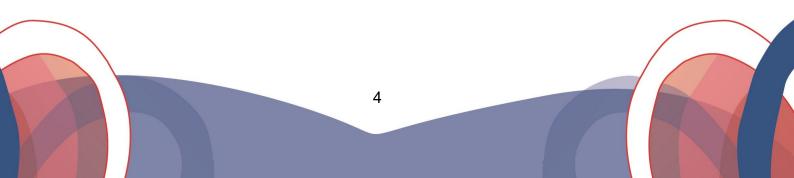
If you complete this Form Kit, it becomes a health record. The form must not be given to other people or used for anything else unless you agree. This can be done through the Advance Agreement or Advance Consent Direction or if it is written in the *Health Records (Privacy and Access) Act 1997* (ACT).

Your details:		
Your name:Address:		
	Phone Number:	
Email Address:		
How do you want us to conta	act you? Click to choose.	
Phone: Yes/No	Email: Yes / No	Post: Yes / No



PART 1: NOMINATED PERSON APPOINTMENT

Und	der Section 19 of the <i>Mental Health Act 2015</i> (ACT) your Nominated Person can:
	help you make decisions
	help you understand your rights
	be contacted when important decisions about you are made
	have information about you
	help you to explain things to other people
	be with you at the ACT Civil and Administrative Tribunal
_	portant: the person you name can say no to being nominated. Sometimes, the Chief ychiatrist can also say no.
No	minated person details: you need to fill this out
I ch	noose the following person:
Naı	me of Nominated Person:
Add	dress:
Pho	one Number:Email:
	ur Signature:Date:
No	minated person confirmation: the Nominated Person needs to sign this
As	the Nominated Person, I:
•	am over 18 years old can act as the Nominated Person have time to do this agree to be the Nominated Person know if the person nominating me has an Advance Agreement and Advance Consent Direction
•	have read these documents.
Noi	minated Person's Signature:Date:



PART 2: ADVANCE AGREEMENT

☐ information about what treatment you want for your mental health

contact details for your family and friends and others such as psychiatrist
 what should happen with your family, pets and bills if you become unwell
 information about you, such as languages you speak or other illnesses

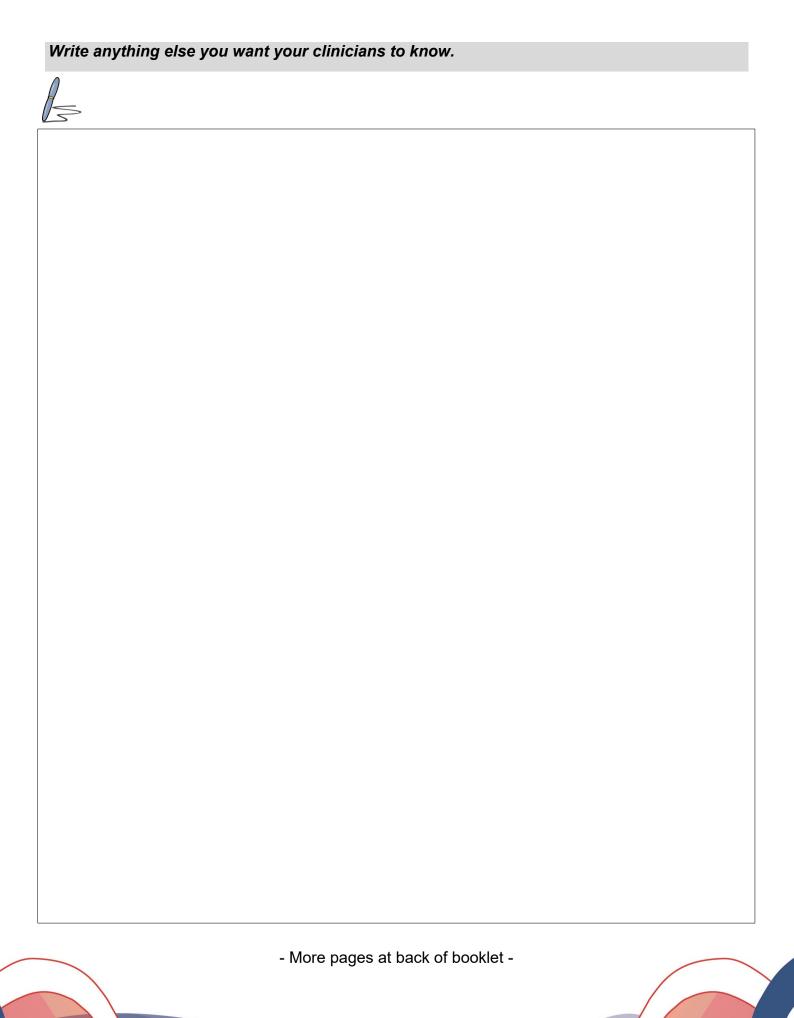
Under Section 26 of the Mental Health Act 2015 (ACT).

Your Advance Agreement has:

The information in the form will be used in the future. You will still be able to ma form as you want. You can add more page	ike some decisio	•
Sometimes, your clinicians can change s are not reasonable or practical to follow.	some of your dec	isions in your Advance Agreement if they
Advance Agreement details: you	u need to fill th	is in
Do you have children or other people you	ı care for?	Yes / No
If yes, who do you want to look after them	if you can't?	
Name:		_
Address:		
Phone:	Email:	
Do you have pets? Yes / No		
If yes, who do you want to look after ther	n if you can't?	
Name:		
Address:		
Phone:	Email:	



Please list any other health issues you have.
Please list any medication you take.
Please list languages you speak and cultural or spiritual traditions that you want clinicians to know about.
Please list the things that help you when you are feeling distressed.
Are there any Domestic Violence or Family Court Orders in place that you want the treating team to know about that may impact your care or the care of your dependents or pets?



Contact details of your family, friends and other people

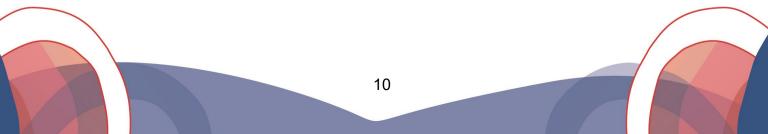
Write details here if you want to		
	Name	Contact
		Phone:
Nominated Person		Email:
Carer		Phone:
Calei		Email:
Family or friends		Phone:
r arrilly or frierius		Email:
Family clinician or		Phone:
GP		Email:
Development		Phone:
Psychiatrist		Email:
Davohologist		Phone:
Psychologist		Email:
Support Worker		Phone:
Support Worker		Email:
Guardian		Phone:
Guardian		Email:
Power of		Phone:
Attorney		Email:
Cooled Worker		Phone:
Social Worker		Email:
Othor		Phone:
Other		Email:
Othor		Phone:
Other		Email:

Contact details for people who are helping you

Write details here if you want to		
	Name	Contact
Person who looks after your children or people you care for		Phone: Email:
Person who looks after your pets		Phone: Email:
Person who collects your mail		Phone: Email:
Person who looks after your social media		Phone: Email:
Person who pays your bills		Phone: Email:
Contact person at work		Phone: Email:
Other		Phone: Email:

Signatures for Advance Agreement

You must sign here	
Signature:	Date:
If you have a Nominated Person, they n	nust sign here:
Name:	
Signature:	
Your treating team member must sign h	nere (most often a GP or psychiatrist):
Name:	
·	ision-making capacity to fill in this form and that the e form are within my professional scope of practice.
Signature:	Date:
Contact details:	
Other person who is helping you shoul	d sign here (optional):
Name:	
Signature:	



PART 3: ADVANCE CONSENT DIRECTION

Under Section 27 of the Mental Health Act 2015 (ACT).

treatment, care, support, medications and procedures you agree to
☐ treatment, care, support, medications and procedures you DON'T agree to
□ people you want us to contact
□ people you DON'T want us to contact
□ your decision about having or not having Electroconvulsive Therapy
The information in the form will be used by your clinicians if you CAN'T make your own decisions in the future. Remember that you will still be able to make some decisions. You can complete as much of this form as you want.
Sometimes, your clinicians may need to make decisions for you. This can only happen if it's an emergency or your clinician gets permission from the ACT Civil and Administrative Tribunal.
You agree or you <u>DON'T</u> agree
I will try any medication or treatment my clinicians recommend. Yes / No
If yes, you can leave the rest of this form blank.
AGREEMENT:
I agree to the following treatment and care for my current mental health:

If you CAN'T make decisions in the future, your Advance Consent Direction has information about:



AGREEMENT:
I agree to the following medication and procedures for my current mental health condition:
DON'T AGREE:
I DON'T agree to the following treatment and care for my current mental health:
I DON'T agree to the following medications or procedures for my current mental health condition:

Contact details of people you want us to talk to if you <u>CAN'T</u> make some decisions

Write details only if you want to.

Name	Contact
	Phone:
	Email:

Details of people you <u>DON'T</u> wish to be given information about yourself.

Write details only if you want to.

Name	Who is this person to you (e.g. sister, neighbour)

Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is a treatment for major depression, bipolar disorder and psychotic illnesses like schizophrenia. Medication and psychological therapy may also be given.

Do you	agre	e to	Electroconvulsive Therapy (ECT)? Tick one:
Ţ	⊒ Ye		as a first treatment
[⊒ Ye	l es d	f yes, how many times? (not more than 9) only if other treatments have not worked
		I	f yes, how many times? (not more than 9)
	⊒ No)	
Signa	ture	s fo	or Advance Consent Direction
You m	ust s	ign l	here.
Signatu	ure:		Date:
Witnes	s 1 n	nust	sign here. This person can't be part of your treating team.
Name:			_
			sses must not be the Carer, Nominated Person, Power of Attorney or Guardian
Signatu	ıre:		Date:
			sign here ONLY if you ticked yes to ECT. This person can't treating team.
Name:			
Signatu	ıre:		Date:
Your ti	roatir	na to	am member must sign here (most often a GP or psychiatrist):
		•	
☐ Iar	n sat	isfie	d that the person has decision-making capacity to fill in this form and that the ussed and agreed to in the form are within my professional scope of practice.
Signatu	ıre:		Date:
Contac	t deta	ails:	
			sign here. This person can't be part of your treating team.
Signatu	ıre:		Date:
Witnes treatin			sign here ONLY if you ticked yes to ECT. This person can't be part of your
Name:			
Signatu	ıre:		Date:

Signature Checklist

Did you sign this form?

Nominated person – signature on Page 4	Yes / No
Advance Agreement – signatures on Page 10	Yes / No
Advance Consent Direction – signatures on Page 15	Yes / No

Where does your Form Kit go?

Once your Form Kit is signed, you must give a copy to:

Person	Given to
You	Yes / No
Your Nominated Person, if you have one	Yes / No
Your Guardian, if you have one	Yes / No
Your Power of Attorney, if you have one	Yes / No
Any clinician who can access your health information	Yes / No
Any clinician who can't access your health information	Yes / No

You may want to give the Form Kit to:

Person	Distributed
Your Carer, if you have one	Yes / No
Other people who are helping you	Yes / No
If you are not a patient at Canberra Health Services Mental Health, Justice Health and Alcohol and Drugs Service (MHJHADS), you can email it to TribunalLiaison@act.gov.au . They will add it to Canberra Health Services system.	Yes / No
Other – Name:	Yes / No
Other – Name:	Yes / No
Other – Name:	Yes / No

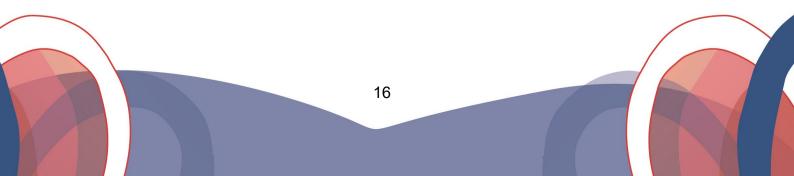
Your Nominated Person, Advance Agreement or Advance Consent Direction is legal until it is cancelled or changed. This Form Kit has your views, wishes and decisions. Read this Form Kit at least once a year to see if you want to change it.

Changes

If you can make decisions, you can make changes at any time by completing a new Form Kit. If you are filling in your Form Kit on a computer you can save it and change it later.

Cancelling

You can stop your Nominated Person, Advance Agreement or Advance Consent Direction at any time. You can only do this if you can make decisions. You need to let your treating team know of this.



More pages for information if needed					

More pages for information if needed					

More pages for information if needed					

INFORMATION FOR CLINICIANS ON HOW TO SUBMIT THIS FORM KIT

For forms signed by a Canberra Health Services: Mental Health, Justice Health and Alcohol and Drugs Service (MHJHADS) treating team member, the treating team member must:

- 1. Confirm that the form has been properly signed for the parts which are filled in (See signature checklist on page 16).
- 2. Insert the person's URN on page 3.
- 3. Scan the form into the person's electronic clinical record (MAJICeR):
 - ☐ Title the scanned form according to what has been filled out (e.g. if all parts of the form have been completed, use the title 'Nominated Person Advance Agreement Advance Consent Direction'; if only the Advance Agreement section has been completed, title the document 'Advance Agreement').
 - ☐ A reference to the completed documents should be added to the 'Alert' section. Alerts should be added through the Clinical Portal so that they will appear in both MAJICeR and ACTPAS.
- 4. Provide a copy of the form to the relevant people (See page 16).
- 5. Provide mental health treatment, care and support in accordance with the form, as set out in the *Mental Health Act 2015* (ACT).

For forms signed by other clinicians (e.g. GPs, private mental health professionals), the clinician must:

- 1. Confirm that the form has been properly signed for the parts which are completed (See signature checklist on page 16).
- 2. Scan, or keep a copy of, the form in the person's clinical record.
- 3. If you are the representative of the person's treating team—provide a copy of the form to the relevant people (See page 16).
- 4. If the consumer agrees, send a copy to Canberra Health Services for uploading to their system by email to TribunalLiaison@act.gov.au.
- 5. Provide mental health treatment, care and support in accordance with the form, as set out in the *Mental Health Act 2015* (ACT), and provide this form with any referrals to hospital.

