ACT Mental Health Consumer Network

Endorsed by:

ACT Government | Canberra Health Services

My Rights, My Decisions Form Kit

CONTENTS

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:

ACT Government | Canberra Health Services

ADACAS ADVOCACY

RKA RESPECT - KNOW - ACT

Legal Aid ACT

CarersACT

ACT HUMAN RIGHTS COMMISSION
Australian Capital Territory

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:

Date of Birth:_____Phone Number: _____

URN (office use only):_____

Email Address: _____

How do you want us to contact you? Click to choose.

Phone: Yes / No Email: Yes / No Post: Yes / No

PART 1: NOMINATED PERSON APPOINTMENT

Under Section 19 of the *Mental Health Act 2015* (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

Important: the person you name can say no to being nominated. Sometimes, the Chief Psychiatrist can also say no.

Nominated person details: you need to fill this out

I choose the following person:

Name of Nominated Person: _____

Address:

Phone Number:_____Email: _____

Your Signature:_____Date: _____

Nominated 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.

Nominated Person's Signature:_____Date: _____

PART 2: ADVANCE AGREEMENT

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

Your Advance Agreement has:

- ❑ 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

The information in the form will be used by your clinicians if you can't make your own decisions in the future. You will still be able to make some decisions. You can complete as much of this form as you want. You can add more pages if you want.

Sometimes, your clinicians can change some of your decisions in your Advance Agreement if they are not reasonable or practical to follow.

Advance Agreement details: you need to fill this in

Do you have children or other people you 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 them 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?

Write anything else you want your clinicians to know.

- More pages at back of booklet -

Contact details of your family, friends and other people

Write details here if you want to		
	Name	**Contact**
Nominated Person		Phone: Email:
Carer		Phone: Email:
Family or friends		Phone: Email:
Family clinician or GP		Phone: Email:
Psychiatrist		Phone: Email:
Psychologist		Phone: Email:
Support Worker		Phone: Email:
Guardian		Phone: Email:
Power of Attorney		Phone: Email:
Social Worker		Phone: Email:
Other		Phone: Email:
Other		Phone: 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:
Other		Phone: Email:
Other		Phone: Email:
Other		Phone: Email:
Other		Phone: Email:
Other		Phone: Email:

Signatures for Advance Agreement

You must sign here

Signature:_____ Date:_____

If you have a Nominated Person, they must sign here:

Name:_____

Signature:_____ Date:_____

Your treating team member must sign here (most often a GP or psychiatrist):

Name:_____

❑ I am satisfied that the person has decision-making capacity to fill in this form and that the matters discussed and agreed to in the form are within my professional scope of practice.

Signature:_____ Date:_____

Contact details:

Other person who is helping you should sign here (optional):

Name:_____

Signature:_____ Date:_____

PART 3: ADVANCE CONSENT DIRECTION

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

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

- ❑ 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 DON'T 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:

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 CAN'T make some decisions

Write details only if you want to.

Name	Contact
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Details of people you DON'T 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 agree to Electroconvulsive Therapy (ECT)? Tick one:

- ❑ Yes as a first treatment
  If yes, how many times? _____ (not more than 9)
- ❑ Yes only if other treatments have not worked
  If yes, how many times? _____ (not more than 9)
- ❑ No

Signatures for Advance Consent Direction

You must sign here.

Signature:_____ Date:_____

Witness 1 must sign here. This person can't be part of your treating team.

Name:_____

Important: Witnesses must not be the Carer, Nominated Person, Power of Attorney or Guardian

Signature:_____ Date:_____

Witness 2 must sign here ONLY if you ticked yes to ECT. This person can't be part of your treating team.

Name:_____

Signature:_____ Date:_____

Your treating team member must sign here (most often a GP or psychiatrist):

Name:_____

❑ I am satisfied that the person has decision-making capacity to fill in this form and that the matters discussed and agreed to in the form are within my professional scope of practice.

Signature:_____ Date:_____

Contact details:

Witness 1 must sign here. This person can't be part of your treating team.

Name:_____

Signature:_____ Date:_____

Witness 2 must sign here ONLY if you ticked yes to ECT. This person can't be part of your treating team.

Name:_____

Signature:_____ 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.