



ACT
Mental Health
Consumer Network

Endorsed by:



ACT
Government

**Canberra Health
Services**

My Rights, My Decisions Form Kit



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To SUBMIT your completed My Rights My Decisions Form Kit:

If your treating team is part of Canberra Health Services—your treating team member should upload your kit to the Canberra Health Services system. If your treating team is not part of Canberra Health Services—you can email it to TribunalLiaison@act.gov.au for uploading on to the Canberra Health Services system. See back page for full instructions.

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My Rights, My Decisions intellectual property resides with the ACT Mental Health Consumer Network Inc. Individuals and organisations may utilise the forms and other documentation that forms *My Rights, My Decisions* however must not alter the formal content and formatting.

The *My Rights, My Decisions Form Kit* was developed with input from consumers in the ACT Mental Health Consumer Network Inc. and in collaboration with:



Canberra Health
Services



ACT HUMAN RIGHTS
COMMISSION
Australian Capital Territory

MY RIGHTS, MY DECISIONS FORM KIT

The My Rights, My Decisions form kit provides an opportunity for mental health consumers to let their views, wishes and decisions be known in advance. It allows you to express yourself while you have decision-making capacity (with support, if required). Your views can then be taken into account by treating professionals if you are unable to participate fully in decisions about your mental health treatment and care in the future. **Note:** Your treating team may not follow your preferences in an emergency situation, or if they believe that your decisions are unsafe or inappropriate, and the ACT Civil and Administrative Tribunal agrees that a different treatment is required.

This form has been developed with mental health consumers to help you to uphold your rights and decisions as set out by the *Mental Health Act 2015* (ACT). It includes three parts. Please tick the section(s) you choose to complete:

- ☐ **Nominated Person** – where you can choose someone to help you make decisions, express your views and receive information about your treatment, care and support. This may be a friend, a carer, a family member, or other person you trust and feel comfortable with. You do not have to have a nominated person but it is recommended for your benefit. See page 4.
- ☐ **Advance Agreement** – where you can give information that may be useful if you have reduced decision-making capacity (also known as impaired decision-making capacity). This can include your preferences for treatment, what should happen at home to your family, pets, bills and so on, and any relevant information about you, such as languages you speak or other health conditions you have. See page 5. **Note:** To be discussed with and signed by your treating clinician.
- ☐ **Advance Consent Direction** – where you can make your consent to treatment, care and support known if you have reduced decision-making capacity. This is where you can say what treatments, including medications, you agree to or do not agree to, and who should or should not receive information about you. See page 11. **Note:** To be discussed with and signed by your treating clinician.

You can complete one or more parts of the form. You do not have to complete all parts, but it is recommended you do so for your benefit. You must have decision-making capacity when you complete any part of the form.

Your details: to be completed by you

Your name: _____

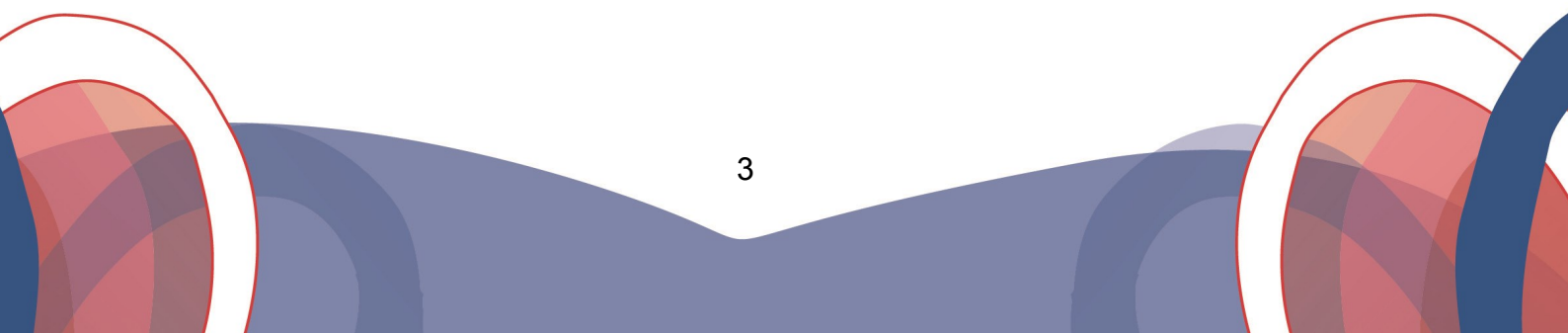
Address: _____

Date of Birth: _____ Phone Number: _____

URN (to be inserted by Canberra Health Services only): _____

Email Address: _____

Preferred method of contact: Phone: Yes / No Email: Yes / No Mail: Yes / No



PART 1: NOMINATED PERSON APPOINTMENT

Under Section 19 of the *Mental Health Act 2015* (ACT).

Your Nominated Person is able to:

- support you to make decisions
- advocate for your decisions and rights
- be consulted in decisions affecting you (for example if an application is made for a mental health order)
- receive information about you
- help you to express your views
- attend the ACT Civil and Administrative Tribunal

Note: Appointment can be ended by the person you appointed at any time, or by the Chief Psychiatrist in limited circumstances.

☐ I have a nominated person I want to keep (attach). You do not need to complete details below.

Nominated person details: to be completed by you

I appoint the following person as my Nominated Person:

Name of Nominated Person: _____

Address: _____

Phone Number: _____ Email: _____

Your Signature: _____ Date: _____

Nominated person confirmation: to be completed by Nominated Person

As the Nominated Person, I confirm that I:

- am an over 18 years
- am able to perform the duties of the nominated person
- am readily available
- agree to the nomination
- am aware of whether the person nominating me has an Advance Agreement and Advance Consent Direction, and I am familiar with the content of these

Nominated Person Signature: _____ Date: _____

PART 2: ADVANCE AGREEMENT

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

Your Advance Agreement sets out:

- your mental health treatment preferences
- contact details for people you wish your treating team to know about
- what should happen at home with your family, pets, bills and so on, if you become unable to look after these things
- any relevant information about you, such as languages you speak, or other health conditions you have, that you wish your treating team to know about

The information in the form will be considered by your treating team if you have reduced decision-making capacity in the future. Note that just because your decision-making may be reduced in one area, it does not mean that it is reduced in all areas of your life. You can complete as much or as little of this form as you choose. Attach pages if necessary.

Note: Your treating team may override your treatment preferences in your Advance Agreement if they are not reasonably practicable to follow.

☐ I have an Advance Agreement I want to keep (attach). You do not need to complete this section.

Advance Agreement details: to be completed by you

Do you have dependents? Yes / No

If yes, who do you want to look after them if you are unable to?

Name: _____

Address: _____

Phone: _____ Email: _____

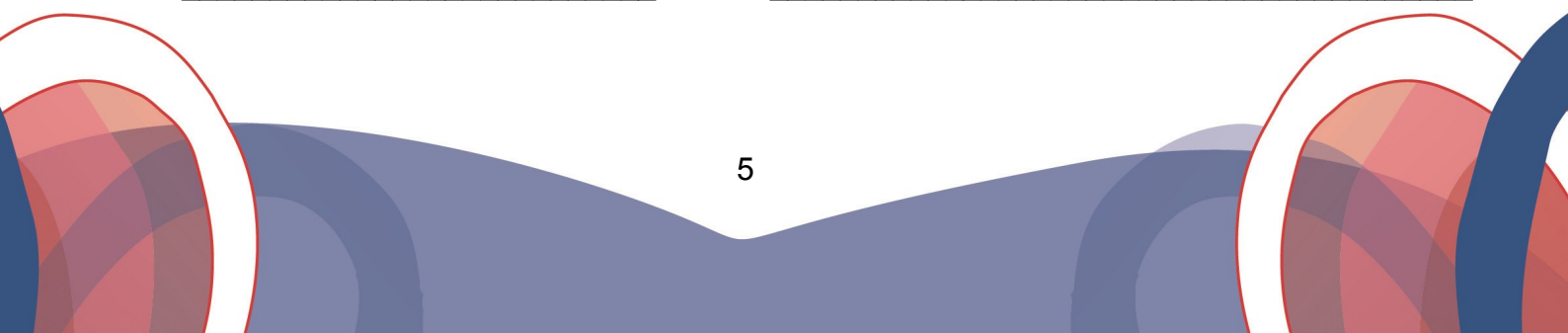
Do you have pets? Yes / No

If yes, who do you want to look after them if you are unable to?

Name: _____

Address: _____

Phone: _____ Email: _____



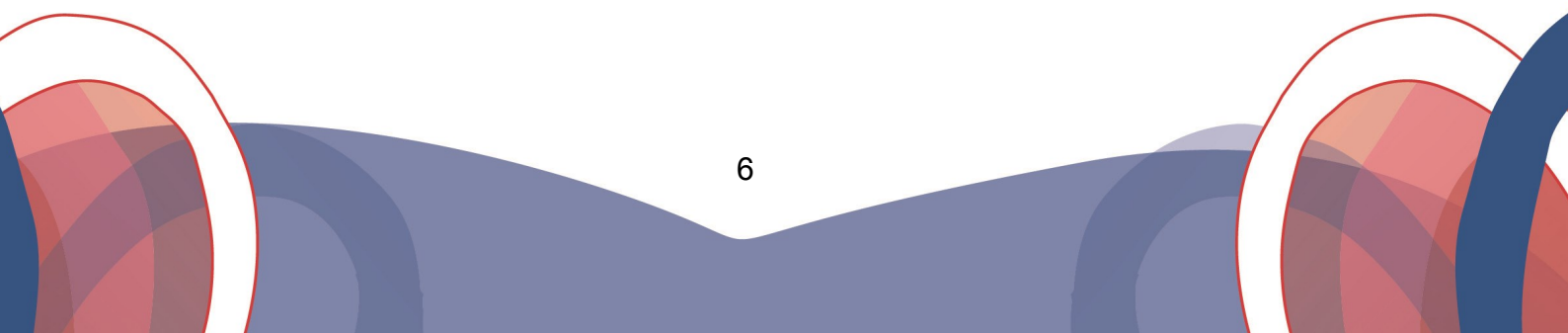
Do you have other health issues? Yes / No

If yes, list them and any treatments _____

Is there other personal information, such as languages you speak, cultural or spiritual traditions, that you would like the treating team to be aware of? _____

Are there things that help you when you are 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?



The space below is for you to write whatever you would like your treating team to know about your treatment preferences and when you would like to be supported to make decisions. It is up to you whether you complete this section. Please do not include Consent information that should be included in an Advance Consent Direction.



- Additional pages at back of booklet -

Contact details for people associated with you

<i>Enter details only if applicable and if you choose</i>		
	Name	Preferred Contact
Nominated Person		Phone: Email:
Carer		Phone: Email:
Family/friends		Phone: Email:
General Practitioner		Phone: Email:
Psychiatrist		Phone: Email:
Psychologist		Phone: Email:
Support Worker		Phone: Email:
Guardian		Phone: Email:
Power of Attorney		Phone: Email:
Other		Phone: Email:
Other		Phone: Email:
Other		Phone: Email:

Contact details for people providing practical help

<i>Enter details only if applicable and if you choose</i>		
	Name	Preferred Contact
Look after dependents		Phone: Email:
Look after pets		Phone: Email:
Collect mail		Phone: Email:
Maintain social media		Phone: Email:
Pay bills		Phone: Email:
Contact 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 (mandatory signature)

Signature: _____ Date: _____

Nominated Person (if you have one — mandatory signature):

Name: _____

Signature: _____ Date: _____

Treating team member (most often a GP or psychiatrist, mandatory signature):

Name: _____

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

Signature: _____ Date: _____

Contact details: _____

Person providing practical assistance (optional signature):

Name: _____

Signature: _____ Date: _____

PART 3: ADVANCE CONSENT DIRECTION

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

Your Advance Consent Direction sets out, if you have reduced decision-making capacity in the future:

- the treatment, care, support, medications and procedures you do consent to
- the treatment, care, support, medications and procedures you do NOT consent to
- the people you wish to be contacted
- the people you do NOT wish to be contacted
- your consent or non-consent to Electroconvulsive Therapy

The information in the form comes into effect if you have reduced decision-making capacity in the future. Note that just because your decision-making may be reduced in one area, it does not mean that it is reduced in all areas of your life. You can complete as much or as little of this form as you choose.

Note: Your consents may be over-ridden in a mental health emergency or if your treating team applies to the ACT Civil and Administrative Tribunal.

☐ I have an Advance Consent Direction I want to keep (attach). You do not need to complete this section.

You consent or do not consent:

I am willing to try any medication or treatment anyone treating me recommends.

Yes / No

If yes, you can leave this section blank.

CONSENT:

I consent to the following treatment, care and support for my current mental health condition (for example, Cognitive Behaviour Therapy and Oral Medication).

11

CONSENT (continued):

I consent to the following medication and procedures for my current mental health condition:

DO NOT CONSENT:

I do not consent to the following treatment, care and support for my current mental health condition (for example, long term injected medication).

I do not consent to the following medications or procedures for my current mental health condition:

Contact details of people you wish to be provided with information if you have reduced decision-making ability

Enter details only if applicable and if you choose.

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

Details of people you DO NOT wish to be provided with information if you have reduced decision-making ability

Enter details only if applicable and if you choose

Name	Relationship

Electroconvulsive Therapy

Electro-convulsive therapy (ECT) is a form of medical treatment for major depression, bipolar disorder and psychotic illnesses including schizophrenia. Medication and psychological therapy may also be given.

Do you consent 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: (mandatory signature)

Signature: _____ Date: _____

Witness 1: (mandatory signature; not part of treating team)

Name: _____

Signature: _____ Date: _____

Witness 2: (mandatory signature ONLY if yes to ECT; not part of treating team)

Name: _____

Signature: _____ Date: _____

Treating team member (most often a GP or psychiatrist, mandatory signature):

Name: _____

☐ I am satisfied that the person has decision-making capacity to complete 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: (mandatory signature; not part of treating team)

Name: _____

Signature: _____ Date: _____

Witness 2: (mandatory signature ONLY if yes to ECT; not part of treating team)

Name: _____

Signature: _____ Date: _____

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

Signature Checklist

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

Distribution of your form

Once your form is signed, it must be distributed to the following:

Person	Distributed
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 member of your treating team who has access to your health record	Yes / No
Any member of your treating team who does not have access to your health record	Yes / No

You may choose to distribute it to the following:

Person	Distributed
Your Carer, if you have one	Yes / No
One or more persons providing practical help	Yes / No
If you are not currently a Canberra Health Services Mental Health, Justice Health and Alcohol and Drugs Service (MHJHADS) patient, you can send to TribunalLiaison@act.gov.au for uploading onto the 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 binding until it is revoked or updated. You will need to keep this form up to date so that it reflects your current views, wishes and decisions. It is recommended that you review this form at least once a year.

Amending

You may amend your Nominated Person, Advance Agreement or Advance Consent Direction at any time, if you have decision-making capacity, by completing a new form.

Stopping

You can stop your Nominated Person, Advance Agreement or Advance Consent Direction at any time, if you have decision-making capacity, by informing your treating team.

Additional pages



Handwriting practice lines consisting of 20 horizontal lines.

Additional pages



Handwriting practice lines consisting of 20 horizontal lines.

Additional pages



Handwriting practice lines consisting of 20 horizontal lines.

TO SUBMIT THE FORM KIT, FOLLOW INSTRUCTIONS BELOW

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 completed (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.

Privacy statement

Once this form has been completed, it becomes a health record. The form, and any information contained in the form, must not be given to other people or used for any purpose not stated in the form, unless the person has given consent (including through the Advance Agreement or Advance Consent Direction) or unless another exception in the *Health Records (Privacy and Access) Act 1997* (ACT) applies.