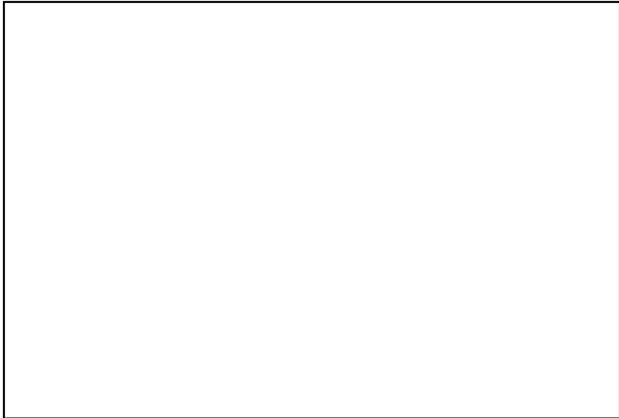
MENTAL HEALTH
Care & Treatment Act

Newfoundland Labrador



Department of Health & Community Services
Mental Health Care and Treatment Act
Sections 40, 41 & 42

PLEASE PRINT LEGIBLY

COPY: ☐Original (must go in file) ☐Patient ☐Patient Representative ☐Rights Advisor

☐Administrator ☐ Treatment Plan Member: ___________________________

Community Treatment Order

SECTION 1: TO BE COMPLETED BY PSYCHIATRIST

I, the undersigned _______________________________________ a psychiatrist within
(please print name in full and include qualifications)
the meaning of the *Mental Health Care and Treatment Act*, certify that on the ____ day of

__________________, 20____, at ____,
(place of examination)
I examined ____
(please print name of person who is the subject of this order)

of __________________________________at ___________________________.
(residence) *(time)*

On the basis of the examination and other pertinent facts respecting the person or the person's condition that are known by or have been communicated to me, I am of the opinion that the person should be subject to a community treatment order based on the following: (*be specific in setting out the results of the examination and the facts relied upon to form the opinion*):

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I am of the opinion that the person:

____ Has a mental disorder for which he or she is in need of continuing treatment or care and supervision in the community;

____ Is likely to cause harm to himself or herself or another, or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care and supervision while residing in the community;

____ Is unable to fully appreciate the nature and consequences of the mental disorder and is therefore unlikely to voluntarily participate in a comprehensive community treatment plan;

_____ Requires services in order to reside in the community so that he or she will not be likely to cause harm to himself or herself or to others, or to suffer substantial mental or physical deterioration or serious physical impairment. These services:

- exist in the community;
- are available to the person; and
- will be provided to the person; and

____ Is capable of complying with the requirements for treatment or care and supervision set out in the community treatment order.

The following criteria have also been met:

____ During the immediately preceding two-year period the person:

(A) Has been detained in a psychiatric unit as an involuntary patient on three or more separate occasions (Dates: 1. ________________, 2. ________________, 3. ________________); or
(mm/dd/yy) *(mm/dd/yy)* *(mm/dd/yy)*

(B) Has been the subject of a prior community treatment order (Date: ________________).
(mm/dd/yy)

____ The person, the psychiatrist who is issuing the community treatment order or his or her designate and another health professional, person or organization involved in the person's treatment or care and supervision have developed a community treatment plan for the person; and

_____ The psychiatrist who is issuing the community treatment order or his or her designate has consulted with the health professionals, persons and organizations proposed to be named in the community treatment plan and each has agreed in writing to be named in the plan as follows:

This community treatment order may be signed in any number of counterparts, each of which is an original and all of which taken together constitute one single document.

________________________________	________________________________
Name of Treatment Team Member (Please Print)	*Signature of Treatment Team Member*
________________________________	________________________________
Name of Treatment Team Member (Please Print)	*Signature of Treatment Team Member*

______________________________	______________________________
Name of Treatment Team Member (Please Print)	*Signature of Treatment Team Member*
______________________________	______________________________
Name of Treatment Team Member (Please Print)	*Signature of Treatment Team Member*
______________________________	______________________________
Name of Treatment Team Member (Please Print)	*Signature of Treatment Team Member*
______________________________	______________________________
Name of Treatment Team Member (Please Print)	*Signature of Treatment Team Member*

I ___________________________________ have issued this order and am responsible for its
(please print name of psychiatrist)
general supervision and management.

The community treatment plan forms a part of this order and is included in Section 4 of this form, under the general supervision and management of ____.
(please print name and position of person responsible for plan)

________________	________________	____________________________
Date CTO Issued	***Time CTO Issued***	***Signature of Issuing Psychiatrist***

SECTION 2: NOTICE OF RIGHTS OF A PERSON SUBJECT TO A CTO AND REVIEW BOARD ADDRESS AND FUNCTIONS

As a person subject to a community treatment order, you have the following rights:

1. To retain and instruct legal counsel without delay in person or by other means. You may contact the Newfoundland and Labrador Legal Aid Office nearest you:

St. John's	1-800-563-9911	Grand Falls-Windsor	489-9081
Carbonear	1-844-596-7835	Corner Brook	1-844-639-9226
Clarenville	1-844-260-7138	Stephenville	1-844-304-5263
Marystown	1-844-340-3068	Happy Valley-Goose Bay	896-5323
Gander	256-3991	Labrador West	282-3425

2. To meet with a Rights Advisor who will:
   - Meet with you and/or your patient representative in person or by other means within 24 hours of the issuance of the community treatment order and again within 10 days after the first meeting, or at any other time at your request;
   - Explain the significance of the issuance or renewal of a community treatment order;
   - Communicate information to you in a neutral and non-judgmental manner;
   - Assist you in making an application for review to the Mental Health Care and Treatment Review Board, at your request;
   - Assist you in obtaining legal counsel, at your request;
   - Attend the Review Board hearing, at your request; and
   - Maintain confidentiality.

   You may contact a Rights Advisor by calling **1-888-546-1222.**

3. You are entitled to receive copies of the following from the administrator or the psychiatrist who is managing the community treatment order:
   - A copy of the community treatment order;
   - All renewals of the community treatment order;
   - Any amendments or variations of the community treatment order;
   - Any termination of the community treatment order; and
   - Any revocation of the community treatment order.

4. If you believe that you should not be subject to a community treatment order, you may make an application to the Mental Health Care and Treatment Review Board to have your community treatment order reviewed.

   The Mental Health Care and Treatment Review Board provides the following functions:
   - Reviews, upholds or overturns involuntary certifications and community treatment orders;
   - Conducts automatic reviews for all community treatment orders; and
   - Reviews and makes recommendations in situations of allegations of unreasonable denials of a right.

The address of the Mental Health Care and Treatment Review Board:

Chair, Mental Health Care and Treatment Review Board
Department of Health and Community Services
PO Box 8700
St. John's, NL A1B 4J6

The location of the application forms required to review your community treatment order can be found at **http://www.gov.nl.ca/health/forms/index.html#6**

Your community treatment order expires 6 months from the date it was issued, *unless it is renewed*. Should you fail to comply with your community treatment order, you may be subject to a further psychiatric assessment and/or apprehension by a peace officer and transported to a psychiatric unit.

SECTION 3: NOTICE OF TRANSFER OF SUPERVISION AND MANAGEMENT RESPONSIBILITIES OF ORDER

I, ________________________________ am unable to carry out my responsibilities under the
(*psychiatrist who issued the order*)

order, and have transferred the general supervision and management responsibilities of the community treatment order to: ____
(*please print name of psychiatrist who is assuming responsibility*)

___________________	________________________________
Date	***Date***
______________________________________	____
Signature of Psychiatrist Who Issued the Order	***Signature of Psychiatrist Assuming Responsibility***

The following amendments have been made to the order:
____
____
____
____

Written notification of this transfer of supervision and management has been given to:
______ The person subject to the community treatment order;
______ The Patient Representative (if applicable);
______ The Rights Advisor; and
______ Each health care professional, person and organization named in the community treatment order.

Written notice was given by:
______ The administrator, where the person who is the subject of the community treatment order was an involuntary patient at the time the order was issued; or
______ The psychiatrist who issued the order, where the person who is the subject of the order was not an involuntary patient at the time the order was issued.

SECTION 4: COMMUNITY TREATMENT PLAN

NOTE: This section forms part of the CTO and should be replaced with a new plan any time a change in plan takes place. Any amended plans for this CTO must be attached to this form.

Date of original plan: ____________________ Date of amended plan: _______________________

Individual's Name: _________________________ Individual's D.O.B.: _____________________

MCP #: __________________________________

Person responsible for the general supervision and management of this plan [*Section 42(e)*]:
Name (please print): ____
Contact #: __________________________ Email:____

Medical Supports:
Psychiatrist's Name (please print): ____
Contact #: __________________________ Email:____

Care/Support/Supervision Obligations [*Section 42(f)*]:______________________________________
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Treatment/Medications: ____
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Reporting Obligations [*Section 41(2)(e)*]:____
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Plan for Prescription Drug Coverage: ____

Alternate Psychiatrist's Name (please print): ____
Contact #: __________________________ Email:____

Care/Support/Supervision Obligations [*Section 42(f)*]:______________________________________
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Treatment/Medications: ____
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Reporting Obligations [*Section 41(2)(e)*]: ____
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Income:
Indicate this individual's source(s) of income: ____
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Housing:
Indicate the housing arrangement that is in place for this individual: _______________________
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Community Supports:
Indicate the community health care professionals, persons and agencies who will be contributing to community-based care, support and supervision under this plan, (e.g. ACT Team, community agency, family member, priest/minister):
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____
____
____

Primary Community Mental Health Service:
Name: ______________________________ Position: ______________________________
Agency: ____
Contact #:_____________________________ Email: ____________________________________

Care/Support/Supervision Obligations [*Section 42(f)*]:______________________________________
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Reporting Obligations [*Section 41(2)(f)*]: ____
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Secondary Services and Supports:
Name: ______________________________ Position: _______________________________________
Agency: ____
Contact #:___________________________ Email: ____

Care/Support/Supervision Obligations [*Section 42(f)*]:_______________________________________
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Reporting Obligations [*Section 41(2)(f)*]: ____
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Name: ______________________________ Position: _______________________________________
Agency: ____
Contact #:____________________________ Email: ____

Care/Support/Supervision Obligations [*Section 42(f)*]:_______________________________________
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Reporting Obligations [*Section 41(2)(f)*]:____
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Name: _____________________________ Position: _______________________________________
Agency: ____
Contact #:___________________________ Email: ____

Care/Support/Supervision Obligations [*Section 42(f)*]:_______________________________________
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Reporting Obligations [*Section 41(2)(f)*]:____
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Name: ________________________________ Position: ________________________________
Agency: ____
Contact #: _____________________________ Email: __________________________________

Care/Support/Supervision Obligations [*Section 42(f)*]:______________________________________
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Reporting Obligations [*Section 41(2)(f)*]: ____
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Crisis Plan:

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Obligation of person subject to the Community Treatment Order

The person who is the subject of this plan shall comply with the above conditions including:

- Attending appointments with physicians, other health professionals and organizations; and
- Taking medications and accepting other prescribed treatment/support.

Failure to Comply: (*Section 51*)

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Regional health authorities acknowledge and respect the privacy of individuals. This personal information is being collected under the Authority of Sections 32 and 33 of the *Personal Health Information Act*, and will be used for plan of care. Please direct any questions about this collection to the Privacy Officer within your region.