Community Treatment Order Provincial Quality Assurance Review

Final Report

June 2, 2017

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Executive Summary

Introduction

Under the *Mental Health Care and Treatment Act*, community treatment orders (CTOs) provide mandated treatment and care in the community under the supervision of the treating psychiatrist and other health care providers, such as a case manager or an assertive community treatment (ACT) team. While community treatment orders can operate as important clinical tools for treating clients outside hospital settings, procedural irregularities in the administration of CTOs have been identified. To ensure CTOs are implemented in accord with patient needs and the provisions in the Act, the Department of Health and Community Services initiated a provincial quality assurance review of the processes surrounding the issuance, administration, monitoring, and oversight of CTOs. The review took place from September 2016 to February 2017 and was led by the Newfoundland and Labrador Centre for Health Information.

Methods

The review covered CTOs issued from June 2014 to August 2016. Review methods included:

- Key informant interviews and focus groups with 64 respondents across the province involved in the issuance, administration, implementation, and monitoring of CTOs.
- Document review of all CTOs, including any associated forms (Please refer to Appendix A for forms: MHCTA-03, MHCTA-04, MHCTA-07, MHCTA-08, MHCTA-13, MHCTA-14).
- Review of rights advisor log books and rights advisor workload documentation forms.
- Review of administrative files of the Mental Health Care and Treatment Review Board (Review Board)

Results

Utilizing a question framework produced by the Department of Health and Community Services in collaboration with the Provincial CTO Working Group, this review aimed to address the following four objectives.

Objective 1: To assess the issuance of CTOs by examining the process of the initial psychiatric assessment, completion of the CTO documentation, and development of the community treatment plan, in order to identify any variances between legislated requirements and current practices.

- There were 15 instances identified in which variances between legislative requirements and practices may have been due to procedural irregularities, such as cases, for example, where a community treatment plan was not recorded or all appropriate individuals were not provided with copies of the CTO. The review suggests processes have improved over time with only 2 procedural irregularities identified for CTOs issued since April 2016.
- For 81 CTOs issued during the period under review, notifications to Telelink were made in 26 cases. There is evidence that rights advisors made contact with CTO clients within 24 hours in at least 28 cases, however, processes regarding rights advisor notification and follow-up have improved. Of 11 CTOs issued across the province from April 2016 to August 2016, notifications were made to Telelink in 8 cases and there was only 1 case in which 24 hour contact with a rights advisor may not have occurred.

Objective 2: To assess the administration of CTOs, including an examination of how CTOs and community treatment plans are carried out by the treatment teams and other appropriate individuals.

- There were no issues identified with the documentation or communication practices of treatment teams, however, challenges with regard to CTO implementation in the community included: finding suitable housing for CTO clients, transporting clients to hospital (in rural areas), and challenges accessing managing psychiatrists.
- There was evidence of some miscommunication or misunderstanding among RNC/RMCP and health care professionals regarding the role of peace officers in the administration of CTOs.

Objective 3: To assess the effectiveness of the monitoring and oversight of CTOs, including a review of auditing and quality assurance activities which are undertaken by the regional health authorities.

- The Administrator should receive a copy of all CTO-related documents issued in their region. One challenge regarding oversight is that there is no way for administrators to ensure they have files on all individuals detained in the community, particularly if CTOs are issued by private practice psychiatrists or renewed while an individual is residing in the community.
- Available data suggests that prior to April 2016, all mandatory reviews by the Review Board were not undertaken, though there is evidence to suggest that the review process has improved. Some respondents suggested that the creation of a central and regularly monitored electronic database for CTOs could also help to ensure all reviews take place.
- Auditing or regular review processes for CTOs are in place within Eastern, Western, and Central Health. Within Labrador-Grenfell Health, case managers follow CTOs to ensure processes are being followed.

Objective 4: To assess the quality assurance practices in place to ensure the legislation is reflective of best practices and patient needs.

- Key informants felt that the legislation was generally clear. The deterioration clause was identified as useful because it allows clinicians to take action to prevent patients from becoming unwell.
- Clients interviewed for this review felt that their CTO helped with their recovery.
- While each region described regular review processes or indicated CTOs are followed by case managers to ensure processes are followed, there was also a clear need for enhanced education on CTOs across the province. Education should be provincially directed and consistent across professions and organizations.

While procedural irregularities occurred over the course of the review period, the review suggests that practices have improved since April 2016, in particular with regard to adherence to legislative requirements regarding the CTO form and contents as well as requirements related to rights advisors. Moving forward, enhanced auditing practices and additional education on CTOs, can help to ensure the quality of CTOs and ensure that understanding and practices related to CTOs reflect legislation. Efforts to enhance practices regarding CTO administration, education, and auditing are already underway at both regional and provincial levels. The findings of this review can help to guide these efforts.

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1.0 Introduction

The *Mental Health Care and Treatment Act* came into effect on October 1, 2007. The purpose of the legislation is to clearly communicate what an individual can expect from the health and community services system if involuntarily admitted to hospital or placed on a community treatment order. The Act defines a range of processes and roles including the processes of involuntary admission, treatment, and discharge; the process of administering Community Treatment Orders; the roles of rights advisors; and the role of the Mental Health Care and Treatment Review Board. Under the *Act*, community treatment orders (CTOs) provide mandated treatment and care in the community under the supervision of the treating psychiatrist and other health care providers, such as a case manager or an assertive community treatment (ACT) team. In light of identified procedural irregularities in the administration of CTOs, the Department of Health and Community Services (DHCS) initiated a provincial quality assurance review of the processes surrounding the issuance, administration, monitoring, and oversight of CTOs. The review took place from September 2016 to February 2017. This report details the results of the review.

1.1 Objectives

In accord with objectives determined by the Department of Health and Community Services, this review examined the processes surrounding the issuance, administration, monitoring and oversight of CTOs issued in the province from June 2014, when the amendments affecting CTOs were enacted, to August 2016. The review had four guiding objectives:

- To assess the issuance of CTOs by examining the process of the initial psychiatric assessment, completion of the CTO documentation, and development of the community treatment plan, in order to identify any variances between legislated requirements and current practices.
- To assess the administration of CTOs, including an examination of how CTOs and community treatment plans are carried out by the treatment teams and other appropriate individuals.
- To assess the effectiveness of the monitoring and oversight of CTOs, including a review of auditing and quality assurance activities which are undertaken by the regional health authorities.
- To assess the quality assurance practices in place to ensure the legislation is reflective of best practices and patient needs.

1.3 Review Framework

The quality assurance review framework was developed by the Department of Health and Community Services in consultation with the Provincial CTO Working Group (Table 1). The framework defines the specific questions the review aimed to answer, the data sources for those questions and the collection method. Table 1 in this report indicates the report section that addresses specific questions outlined in the review framework.

Table 1. Provincial CTO Quality Assurance Review Framework

Data Source	Questions	Collection Method	Report Section
RHA contact & regional MH/A Directors	• Do you think the legislated requirements for issuing a CTO are clear?	Key informant interviews	3.1
	• How is the deterioration clause, as currently worded in the Act, used and is it helpful?	Key informant interviews	3.2
	• Are the appropriate processes for issuing CTOs being followed?	Key informant interviews/Document Review	3.6
	• Who fulfills the role of administrator in your RHA, and what is your understanding of that role as it relates to section 44(3) of the Act?	Key informant interviews	3.1
	• Are you experiencing any difficulty implementing CTOs due to lack of community resources and supports? What happens in such situations?	Key informant interviews	3.4
	• Are appropriate individuals being notified of the issuance/renewal/termination of CTOs and the contents of a community treatment plan? How, and when, are they notified?	Key informant interviews/ Document Review	3.6
	• What is the composition of treatment teams?	Key informant interviews/ Document Review	3.5

Data Source	Questions	Collection Method	Report Section
RHA contact & regional MH/A Directors	• Under what circumstances are apprehension orders issued? What happens when an apprehension order is issued?	Key informant interviews	3.6
	• Are all mandatory automatic reviews being undertaken and what is the process of initiating a mandatory automatic review?	Key informant interviews/Document Review	3.6
	• Who is responsible for notifying the Review Board of an automatic review?	Key informant interviews	3.6
	• Do you think CTO forms collect all necessary information?	Key informant interviews	3.1
	• What is the process for revoking a CTO in your practice or region?	Key informant interviews	3.6
	• How often, and why, are CTOs terminated and reinstated?	Key informant interviews	3.6
	• What training, education and supports are available for treatment teams and RHA staff? Is there anything additional needed?	Key informant interviews	3.8
	• What auditing processes are in place within RHAs for monitoring CTOs?	Key informant interviews	3.8
	• How do RHAs use audit information?	Key informant interviews	3.8

Data Source	Questions	Collection Method	Report Section
	• Have recommendations resulting from reviews been implemented? If so, how?	Key informant interviews	3.8
Psychiatrists	• Are you credentialed with an RHA or fee for service?	Key informant interviews	3.5
	• If fee for service, how are you compensated for CTOs, and how does that affect your decision to implement them?	Key informant interviews	3.5
	• Do you think the legislated requirements for issuing a CTO are clear?	Key informant interviews	3.1
	• How is the deterioration clause, as currently worded in the Act, used and is it helpful?	Key informant interviews	3.2
	• What is your experience with CTOs? Have you issued them to clients? Why or why not?	Key informant interviews	3.3
	• Are you aware of the processes required to establish a team in order to implement a CTO?	Key informant interviews	3.5
	• In practice, what processes for issuing CTOs are being followed?	Key informant interviews/ Document Review	3.6
	• Do you have any recommendations on how to improve the usage of CTOs?	Key informant interviews	3.1

Data Source	Questions	Collection Method	Report Section
Psychiatrists	• Are appropriate supports in place in the community to facilitate the implementation of CTOs?	Key informant interviews	3.4
	• Have you had a client(s) who would have benefited from a CTO but the community supports were not in place? If so, what happened as a result?	Key informant interviews	3.4
	• What is your process for making changes to a community treatment plan?	Key informant interviews	3.5
	• In your practice, what happens when an apprehension is ordered?	Key informant interviews	3.6
	• Describe your experience with mandatory reviews. When do they occur, and what is your process for ensuring they take place?	Key informant interviews	3.6
	• Who is responsible for notifying the Review Board of an automatic review?	Key informant interviews	3.6
	• Do you think CTO forms collect all necessary information?	Key informant interviews	3.1
	• What is your process for revoking a CTO?	Key informant interviews	3.6
	• How often, and why, are CTOs terminated and reinstated?	Key informant interviews/Document Review	3.6

Data Source	Questions	Collection Method	Report Section
	• Do you have processes for auditing CTOs? If so, how do you use audit results?	Key informant interviews	3.8
Treatment teams	• Are appropriate supports in place in the community to facilitate the implementation of CTOs?	Key informant interviews	3.4
	• What happens when supports are not available in the community to facilitate the successful implementation of a CTO?	Key informant interviews	3.4
	• Are all appropriate team members involved in the development of a community treatment plan? If not, why?	Key informant interviews	3.5
	• How do treatment team members communicate with each other (e.g. email, telephone, etc.) and how often?	Key informant interviews	3.5
	• How do treatment team members interact with the individual and how often?	Key informant interviews	3.5
	• Does the full treatment team ever meet with an individual or is there a lead member?	Key informant interviews	3.5
	• What happens if / when treatment teams are not able to contact a person subject to a CTO?	Key informant interviews	3.5
	• How do treatment team members document their activities?	Key informant interviews	3.5

Data Source	Questions	Collection Method	Report Section
Treatment teams	• Where is the treatment team's documentation kept and how do they access it?	Key informant interviews	3.5
	• What training, education and supports are available for treatment teams and RHA staff? Is there anything additional needed?	Key informant interviews	3.8
	• Can you describe what happens with a termination or revocation of a CTO in your region?	Key informant interviews	3.8
MHCT Review Board	• Are all mandatory automatic reviews being undertaken and what is the process of initiating a mandatory automatic review?	Key informant interviews/ Review Board Admin Data	3.6
	• Is the Review Board effectively engaged in the oversight process for CTOs?	Key informant interviews	3.6
	• Have you experienced problems with executing any part of your role with CTOs?	Key informant interviews	3.6
Legal Aid representatives	• What has been your experience with CTOs?	N/A – Unavailable for participation	N/A – Unavailable for participation
	• Is Legal Aid effectively engaged in the review process for CTOs?	N/A – Unavailable for participation	N/A – Unavailable for participation
	• Have you experienced problems with executing any part of your role with CTOs?	N/A – Unavailable for participation	N/A – Unavailable for participation

Data Source	Questions	Collection Method	Report Section
	• What improvements could be made to enhance the usage of CTOs?	N/A – Unavailable for participation	N/A – Unavailable for participation
	• How do your clients generally feel about being subject to a CTO?	N/A – Unavailable for participation	N/A – Unavailable for participation
RNC / RCMP	• What has been your experience with CTOs?	Key informant interviews	3.6
	• What has been your experience when apprehending an individual subject to a CTO?	Key informant interviews	3.6
	• How is an individual's privacy protected during a revocation?	Key informant interviews	3.6
Current and former clients	• What is / was your experience being on a CTO?	Key informant interviews	3.7
	• Did it help with your recovery?	Key informant interviews	3.7
	• What worked well? What improvements could be made?	Key informant interviews	3.7
Dept. Health and Community Services	• How are rights advisors audited?	Key informant interviews	3.6
	• Are rights advisors meeting all legislated timeframes?	Document Review	3.6

Data Source	Questions	Collection Method	Report Section
	• Have recommendations resulting from reviews been implemented?	Key informant interviews	3.6

2.0 Methods

2.1 Key Informant Interviews

Interviews and focus groups were completed with individuals across the province involved in the process of issuing, administering, overseeing and monitoring CTOs. Individuals interviewed included regional health authority mental health managers, directors, and psychiatrists and treatment teams, Department of Health and Community Services staff in charge of CTO oversight, RNC and RCMP staff, the Review Board, and CTO clients (Table 2). All private psychiatrists contacted for an interview indicated that they had not issued a CTO from June 2014 to August 2016. No representatives from Legal Aid were available to participate in the review.

Table 2. Interviews and Focus Groups completed for MHCTA Community Treatment Order Review, by Regional Health Authority

Participants	Eastern	Central	Western	Labrador-Grenfell	Total
Mental Health and Addictions managers/directors	3	2	3	3	11
Treatment team members	15	9	7	2	33
RNC/RCMP Staff	N/A	N/A	N/A	N/A	4
Psychiatrists	7	0	3	0	10
Review Board	N/A	N/A	N/A	N/A	1
Department of Health and Community Services staff	N/A	N/A	N/A	N/A	1
CTO clients	2	0	2	0	4
Legal Aid	N/A	N/A	N/A	N/A	0
Total	27	11	15	5	64

2.2 Document Review

Documents reviewed included 1) CTO-related forms completed by psychiatrists, administrators, or other treatment team members from June 2014 to August 2016 including: Community Treatment Orders (MHCTA-03), Community Treatment Plans (MHCTA-04), Notifications Advising a Person that a Community Treatment Order is No Longer in Effect (MHCTA-07), Orders of Apprehension (MHCTA-08), Applications for Review (MHCTA-13), and CTO Checklists (MHCTA-14) (see Appendix A for copies of forms in effect at the time of this review; see Appendix B for copies of forms in effect as of June 2017); 2) rights advisor logs submitted to the Department of Health and Community Services from June 2014 to June 2016; 3) rights advisor work documentation forms submitted to the Department of Health and Community Services 4) Review Board data.

3.0 Results

Results below address each question specified in the review framework. Questions and answers are grouped together such that related topics are addressed in the same section or adjacent subsections. Each section/subjection indicates the framework questions addressed in that section/subsection and includes a brief statement summarizing overall main findings.

3.1 The Role of the Administrator, Legislative Clarity, and the CTO Form

Main findings:

- Criteria for issuing a CTO are clear in the legislation.
- The current CTO form collects all the necessary information.
- The role of the administrator is filled in each regional health authority by the Regional Director of Mental Health and Addictions.
- While the administrator should receive copies of all CTO-related forms issued in the region, there is no way for administrators to be sure they have files on all individuals detained in the community.

3.1.1 The Role of the Administrator

The *Mental Health Care and Treatment Act*, defines an "administrator" as "the person in charge of administrative functions within a psychiatric unit." The role of administrator is referred to in the Act in Sections 43(a); 44(3)(a); 47(2)(a); and 53(3)(a) (Appendix C). These sections indicate that the administrator is responsible for supervision of the CTO, providing copies of the CTO to appropriate individuals, providing written notice to appropriate individuals that the CTO is no longer in effect, and making an application for review of the CTO in cases where the person who is a subject of the CTO was an involuntary patient at the time the CTO was issued. If the person who is the subject of a CTO was not an involuntary patient at the time the CTO was issued, the Act indicates that the managing psychiatrist is responsible for the tasks listed above.

In each regional health authority, the role of administrator is fulfilled by the Regional Director of Mental Health and Addictions. Respondents from Eastern, Central, and Western Health indicated that they understood that in the Act, administrators were responsible for monitoring or supervising CTOs issued to involuntary patients. In Labrador-Grenfell Health the role of administrator was understood as "a general supervisory role." While administrators are responsible for a number of tasks related to CTOs in cases where the patient is involuntary at the time the CTO was issued, in practice, few patients who are issued CTOs are involuntary. Patients who are placed on CTOs while in hospital are typically made voluntary before a CTO is issued. CTO renewals are typically issued to clients already living in the community (under a current CTO).

In all regions, administrators were active in the supervision of all CTOs – though they are not the only individuals active in supervising CTOs. Psychiatrists, and particularly treatment team members, are active in CTO supervision at different levels as well.

The *Mental Health Care and Treatment Act Policy and Procedure Manual* (Appendix D) notes that the regional health authority is responsible for maintaining a file on all individuals detained under the Act, including individuals on CTOs. This responsibility is defined in section 1.40 of the manual, which states that:

The regional health authority shall ensure:

- *An administrative file on all persons detained under the ACT is opened and maintained by the regional health authority. The file shall be in the person's name and shall contain information related to the administration of the ACT in relation to the person. This information will include but not be limited to copies of:*
  - *Certificates and renewal forms*
  - *Passes*
  - *Community treatment orders/variations/expirations/termination/revocation orders; and*
  - *Automatic replies to the Board*
- *Administrative files shall be stored together and managed in a location to be determined by each regional health authority.*

In accord with this policy, in Eastern Health, the administrator keeps a file on all individuals issued a CTO in the region. In Central Health, administrator files are kept at the offices of the ACT Team and active CTOs are reviewed twice yearly. In Western Health, the administrator receives files kept on all CTOs issued in the region. Administrative files for individuals issued CTOs in the Labrador-Grenfell region are kept with the Eastern Health Regional Director of Mental Health and Addictions, as well as with the Regional Director of Mental Health and Addictions for Labrador-Grenfell Health.

While administrators in all regions keep copies of CTO files in accord with provincial policy, it is notable that one respondent commented that while the policy manual indicates that the administrator is supposed to receive a copy of all CTO-related forms in the region, there is nothing in the Act to compel individuals to send copies of CTOs or associated forms to the administrator and no way for administrators to be sure they have files on all individuals detained in the community, particularly in the case of CTOs issued by private psychiatrists.

3.1.2 Clarity of the Legislation

Requirements for issuing a CTO are found in Section 40 of the Act (Appendix C). The requirements also appear on the second page of the current CTO form (Appendix A). Regional health authority managers, directors, and psychiatrists were asked in interviews if they thought the legislated requirements for issuing a CTO are clear. While key informants noted that mental health decisions are inevitably subject to clinical judgement, they felt that the criteria for issuing a CTO were clear and there were no specific questions

about the wording or requirements in the Act. One question raised by some informants, however, related to the whether a CTO must be issued in all cases where someone fulfills the criteria. Key informants indicated that involuntary hospitalizations often occur when individuals cease taking medication after being discharged into the community. The Act requires that for a CTO to be issued, an individual must have been involuntarily hospitalized on three occasions in the last two years or have been the subject of a prior CTO. Some psychiatrists noted that it was not clear in the legislation if a CTO was required to be issued after a third involuntary hospitalization or if a psychiatrist could continue to use judgement until they deem a CTO clinically necessary. One psychiatrist also questioned whether psychiatrists are required to issue a new CTO if a patient is taken off a CTO and then relapses, or whether they can continue to pursue other solutions that do not involve a CTO.

3.1.3 The Current CTO Form

Regional health authority managers, directors and psychiatrists were asked if CTO forms collect all the necessary information. Respondents felt that CTO forms did collect all the necessary information and one psychiatrist additionally noted that the checklist on the CTO form (which asks the issuing psychiatrist to check each legislative requirement for issuing a CTO) was useful to making the legal requirements clear. Some respondents did note that the requirement that each treatment team member sign the CTO form was onerous. In Western Health, it is regular practice for the ACT team leader to sign the form for the ACT team and to issue an acknowledgement letter indicating awareness of the CTO and support of the Community Treatment Plan.

3.2 The Deterioration Clause

Main findings:

- The deterioration clause is important because it allows clinicians to take action to prevent patients from becoming unwell.
- The meaning of deterioration is subjective and open to interpretation; however, use of the deterioration clause is regulated by the Review Board, which has a role in deciding if a patient is at risk of deterioration.
- CTOs are issued to avoid deterioration when clients leave the hospital, particularly when patients may be at risk of harm to themselves or others.
- CTOs can be an important clinical tool for keeping people well.

Section 40(2)(a)(ii) states that one requirement for the issuance of a CTO is that:

> *"If the person does not receive continuing treatment or care and supervision while residing in the community, he or she is likely to cause harm to himself or herself or another, or to suffer* ***substantial mental or physical deterioration or serious physical impairment.****"*

Psychiatrists and regional health authority managers and directors were asked about how this clause was used and if it was helpful. Three separate but related points emerged in these discussions. First, respondents noted that the deterioration clause is important and useful because individuals in the hospital may be well, but there may be a risk that they will deteriorate once they leave. Given this risk, the deterioration clause can be used to issue a CTO, even if the person is not currently a threat to themselves or anyone else. This can be an important clinical tool to maintain a patient's mental health.

Second, there was general agreement that the deterioration clause is subjective, but that some clinical subjectivity is inevitable in the field of mental health. In this respect some psychiatrists suggested that it could help to define "deterioration" either in the Act or in a workshop. However, some participants also noted that while the Act is written in such a way that "deterioration" is broadly defined, it may be difficult to define deterioration in a more detailed way, because deterioration may manifest differently in different clients. One participant noted: "Deterioration for one patient may be different than deterioration for another – so in legislation, it has to be broad."

Finally, while the meaning of deterioration can be both subjective and broad, it was noted that the use of the deterioration clause is regulated by the Review Board, which has a role in deciding if a patient is at risk of deterioration. In accord with the Act, CTOs are reviewed by the Review Board in two instances. First, a person who is the subject of a community treatment order or his or her representative may apply to the Board to review whether the criteria for issuing or renewing an community treatment order are met – such application can be made each time an order is issued or renewed (Section 53(1)(2)). Second, an application must be made to the Board for review of an order at the first (6-month) renewal and then every second renewal after that. In the second instance, it is the administrator who is responsible for making an application for review if the patient was involuntary at the time the CTO was made and the psychiatrist who is responsible for making an application for review if the patient was not involuntary at the time the CTO was made (Section 53(3)(a)(b)). As one participant pointed out, while clinicians use judgement to determine if a patient is at risk of deterioration, the Review Board acts as an important check to ensure that the CTO is warranted. It should be noted, however, that consistent with the legislative requirements for review noted above, not all CTOs are subject to review. For example, if a CTO is issued and then terminated before the first renewal and if the individual subject to the CTO doesn't initiative an appeal themselves, the Review Board would not have any role in regulating the use of the deterioration clause.

In focus groups, psychiatrists noted that CTOs are issued when non-compliance with medication is considered likely, but more importantly, when psychiatrists also feel that without medication, the patient will pose a risk to themselves or others. One psychiatrist stated that "the risk issue has to be emphasized," suggesting that risk is the most important consideration when determining whether to issue a CTO. In another case, a psychiatrist noted that "there are patients who don't do as well as we'd like on medication, and [a CTO may be issued to keep] an eye to the person and ensure they are not getting worse, that the risk hasn't changed." Another psychiatrist noted that CTOs are a last resort, when other supports have been ineffective. In such cases, one psychiatrist suggested, "you have an ethical obligation to treat a patient with what you know is going to work."

As CTOs were recognized as an important clinical tool for keeping people well, psychiatrists from both Eastern and Western Health questioned the requirement in the Act that a patient must have three involuntary hospitalizations in the last two years before a patient can be issued a CTO: “that is a problem,” one psychiatrist suggested, “because sometimes you know a patient is going to get sick – and you can’t put them on CTO.” Some psychiatrists suggested that in some cases, issuing a CTO after only one or two hospitalizations could be in the best interests of a patient’s mental health. This finding echoes the findings of a previous review of the *Mental Health Care and Treatment Act* completed in 2012 in which psychiatrists indicated they had encountered patients they felt could have benefited from being on a CTO, but who did not meet the criteria of three involuntary hospitalizations in the last two years. According to a jurisdictional scan updated by the Department of Health and Community Services in 2017, this aspect of provincial CTO legislation varies from province to province with the number of hospitalizations and the time periods associated with those hospitalizations ranging from 1-3 hospitalizations within the last 2-3 years. In some provinces, prior hospitalization(s) totaling a specific number of days (ranging from 30 to 60 days in the previous 2 to 3 years) constitutes an alternate criteria (Appendix E).

3.4 Community Supports

Main findings:

- Rural areas have fewer supports than urban areas.
- Challenges with regard to CTO implementation included: finding suitable housing for CTO clients, transporting clients to hospital (in rural areas), and challenges accessing managing psychiatrists.
- Where supports fail, clients typically return to hospital.
- There were no cases reported where psychiatrists did not put a client on a CTO because supports weren’t available.
- Some psychiatrists identified an issue with the current fee code/compensation scheme, whereby much of the work of CTO implementation such as completing CTO paperwork and communicating with police, social workers, and ACT team members, is not compensated.

Regional health authority managers and directors, psychiatrists, and treatment team members were asked if appropriate supports were in place in the community to facilitate the implementation of CTOs, if any clients were not being placed on CTOs for lack of supports, and what happens in cases where supports are not in place. Across the province, a number of common themes emerged from these discussions:

- **Rural areas have fewer supports than urban areas.** Throughout the province, informants noted that there are a number of challenges to implementing CTOs in rural areas. There are typically fewer or no specialist supports in rural areas (such as trauma, addictions, or psychology). Rural case managers may be required to coordinate with others working at

distances, which can create scheduling and communication challenges. In some cases, where rural case managers are working alone, they may prefer not to perform injections – in these cases, arranging transportation to a hospital can present a challenge. Finally, rural case managers may have less frequent or timely access to psychiatrists, who are typically based in larger centres.

- **Finding suitable housing for CTO clients can be challenging.** Adequate housing is a key component of CTO success. Across the province, and particularly in urban areas, informants indicated that it can be difficult to find housing. This is because there are few supportive housing arrangements in urban areas, including St. John's and Corner Brook, and when one or more housing arrangements fail, it becomes increasingly difficult to identify other appropriate options.

- **Transportation can sometimes be an issue.** Some rural informants noted that finding ways to transport clients to hospitals for injections has been challenging. In some cases, RCMP assisted, but this solution was not viewed as ideal by police respondents. Recently reduced funding for transportation to appointments for CTO clients was also highlighted in interviews. In the past, CTO clients have been able to access funding from the Department of Advanced Education, Skills and Labour (AES) to get to and from appointments to comply with the CTO. Recently, AES these funding rules have changed. To qualify for transportation assistance, clients must live further than 60km away from their appointment or have 8 or more appointments to attend per month. Without AES support to assist clients with getting to and from appointments, transportation would likely fall to the case manager (if they were able), thus shifting the cost of transporting the client from AES to the regional health authority.

- **There were no cases reported where psychiatrists did not put a client on a CTO because supports weren't available.** However, some treatment team members and regional health authority directors and managers did note that lack of resources could foreseeably create situations where clients could not be placed on CTOs. For example, in Western Health, there are some areas without case managers and a client returning to one of these areas could not be placed on a CTO. A case manager working in Labrador noted that a lack of supportive housing options in Happy Valley-Goose Bay would likely make it difficult to place individuals on CTOs in that area in the future.

- **Where supports are not available or where supports fail, clients typically return to hospital.** A client, for example, with a mental illness who is unable to find housing may end up back at the hospital and be kept there under ALC or "alternate level care" – an arrangement in which the client occupies an acute care bed temporarily while waiting for other options to become available.

- **Access to the managing psychiatrist is a critical community support.** When the managing psychiatrist is unavailable, treatment team members can contact a designate or on-call psychiatrist for support; however, on-call psychiatrists may be reluctant to take actions. For example, if a client misses a number of medication drops (scheduled medication administration, occurring in the community), treatment team members may contact an on-call psychiatrist (if they are unable to contact the managing psychiatrist), but the on-call psychiatrist will often be reluctant to issue an order of apprehension without knowledge of the client. Some treatment team members suggested that it could be helpful to have a CTO coordinator who could offer guidance on what to do in these situations.

- **ACT teams are an important support, but may not always be necessary to manage CTO clients.** While ACT teams offer other types of support in addition to medication administration, some treatment team members suggested that CTO clients may not desire this support. The ACT team typically works to engage individuals who are not taking their medication before issuing an order for apprehension, conveyance and examination, but such engagement can be time consuming and require considerable resources. Some regional health authority respondents suggested that there may be a role for teams or positions specifically geared toward medication administration, in cases where CTO clients do not require or desire other types of support. It should be noted, however, that of the four current and former CTO clients interviewed for this review, all of them highlighted the support they received from ACT teams as an important positive component of their treatment plan.

- **RNC/RCMP represent an important support, but there may be a lack of mutual understanding of the role of law enforcement.** Some interview data suggested that there may have been some situations in which RCMP were asked to apprehend/transport clients without necessary paperwork (an Order of Apprehension). A clear understanding of the role and limits of RCMP/RNC responsibilities with respect to CTO clients is necessary.

- While all of the psychiatrists interviewed for this review were salaried, it is notable that some psychiatrists did identify an issue with the current fee code/compensation scheme, whereby much of the work of CTO implementation, including for example, completing CTO paperwork and communicating with police, social workers, and ACT team members, is not compensated.

3.5 Treatment Team Composition, Communication, and Documentation

Main findings:

- Treatment teams are typically led by ACT team members in urban areas or case managers in rural areas.
- Treatment teams may include family, nurses, community supports, family doctors, and RCMP.
- There may be room for more consultation with treatment teams in the development of community treatment plans.
- Treatment team members in the community typically document their activities in CRMS – an information management system used by health providers in the community, while psychiatrists (who are also part of treatment teams) document their activities in paper files or in Meditech – a hospital-based information management system.
- CTO documentation is stored in different places within the health system, as different individuals keep or are given copies. A number of respondents noted that a centralized documentation system could be useful.

3.5.1 Treatment Team Composition

When asked about the composition of treatment teams, respondents in Eastern Health indicated that it is their policy that individuals on CTOs in St. John's are placed with the ACT team. In rural areas of Eastern, individuals on CTOs are typically placed with a case manager. In Central Health, only one individual has ever been issued a CTO. This individual was placed with the ACT team. In Western Health, individuals on CTOs in Corner Brook are often placed with the ACT team (though this is not an official policy) while individuals on CTOs outside Corner Brook are typically placed with case managers. In Labrador-Grenfell Health, treatment teams are composed of case managers and family physicians. The managing psychiatrist is always part of the treatment team. Table 3 shows the composition of treatment teams according to administrative data collected in each region.

Table 3. CTO Treatment Team Composition, as documented on Community Treatment Plans, June 2014-August 2016

	Eastern		Western		Central		Labrador-Grenfell	
Team Member	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
ACT team	23	68%	22	67%	5	100%	0	0%
Family	11	32%	0	0%	0	0%	0	0%
Case Managers	10	29%	10	30%	0	0%	6	100%
Nurses	8	24%	6	18%	0	0%	4	67%
Community Supports	5	15%	3	9%	0	0%	3	50%
RCMP	3	9%	0	0%	0	0%	0	0%
Family Physicians	1	3%	8	24%	0	0%	2	33%
Total Community Treatment Plans[a, b]	**34**		**33**		**5**		**6**	

[a] Community Treatment Plans are in included with each CTO. While treatment plans for the same individual may have little variation from CTO to CTO, each plan was counted separately. Thus, for example, in Central Health, there were 5 plans for one individual (with each plan associated with a 6 month CTO).

[b] Of 81 CTOs issued in the province, there were three instances in which no accompanying community treatment plan could be located, bringing the total number of community treatment plans reviewed to 78.

Interview results suggested that treatment team members were typically informed of their role in the treatment plan, but were not always consulted in the development of the plan itself. In Eastern Health, where CTO clients in St. John's are placed with the ACT team as a matter of policy, ACT team members are informed of their role, but may not be consulted in the development of the plan. Respondents from Eastern Health reported that more consultation is typical for rural CTO clients. In Western Health, respondents reported that in the past, team members were typically not consulted about the plan or their role. In early 2016, however, a new protocol was established in Western Health in which treatment plan members send an acknowledgement letter indicating they support the treatment plan and are aware of their role. Additionally, the Clinical Nurse Specialist who oversees the development of the plans for patients leaving Western Regional Memorial Hospital holds phone calls or teleconferences with treatment team members. Some treatment team members indicated however, that they felt there was room for still more consultation. Respondents from Labrador-Grenfell Health indicated that while there is generally agreement on clients' needs, no planning meetings are held, rather the psychiatrist decides on the structure of the plan. In Central Health, the plan is developed by the psychiatrist, the lead individual on the ACT team, and a health care professional from acute care.

3.5.2 Treatment Team Communication

Overall, communication patterns among treatment teams across the province were similar. For clients placed with ACT teams, communication is frequent and often in person. The Eastern Health ACT team meets every morning to discuss clients and review written logs. Members of the ACT team in Eastern Health can also leave clinical notes in the community-based information management system used by ACT team members, CRMS (Client Referral Management System). The Western Health ACT team also meets every morning and can communicate with each other at other times on their cell phones. The ACT team in Central Health indicated that they communicate daily regarding their CTO client. In Labrador-Grenfell Health and rural areas of the Western and Eastern region, where teams are typically composed of case managers, nurses, family members, family doctors, and in some cases RCMP, communication tended to occur on an as-needed basis over the phone.

Frequency of treatment team interaction with CTO clients varied from daily to bi-weekly, depending on the client and the plan. The Eastern and Western Health ACT teams reported that interaction one to three times a week was typical. One case manager in rural Eastern reported bi-weekly interaction with her CTO client, while one case manager in Labrador-Grenfell Health reported that she met with her CTO client frequently and, depending on the circumstances, sometimes daily. The Central Health ACT team reported daily contact with their CTO client. While case managers are the "lead" in rural areas, in urban areas, an ACT team member is typically the "lead" or "prime," while other ACT team members contribute to care.

The Eastern Health ACT team indicated that if team members are unable to contact someone subject to a CTO, the protocol is to inform the managing psychiatrist and then make decisions on a case by case basis. In some cases, a week without contact might be normal (for a more transient client who is rarely home) and in other cases, it might be cause for concern (for a client who is usually home). In the other regions, respondents reported that it is very rare that they are unable to contact or locate an individual on a CTO.

3.5.3 Documentation Practices

Across the regions, treatment team members in the community typically document their activities in CRMS while psychiatrists (who are also part of treatment teams) document their activities in paper files or in the hospital-based information management system, Meditech.

In addition to examining documentation practices around everyday activities, this review also explored practices around the storage and movement of CTO-related forms. Within Eastern Health, when a client is issued a CTO in hospital, that documentation is kept with the administrator and copies of the CTO and Community Treatment Plan are sent to the ACT offices. As CTOs are renewed in the community and/or as additional documentation is created (such as applications for review or notices of termination), this documentation is kept at the ACT offices and copies are also sent to the administrator and other appropriate individuals (the patient, the patient representative, and the rights advisor). For clients in St. John's, CTO checklists are typically kept at the ACT offices. In rural Eastern, CTO files are kept by the case manager and the issuing psychiatrist.

Within Western Health, distribution and filing practices for CTO forms are similar to those in Eastern Health. In the case of CTOs issued in hospital, original documentation is kept in hospital and copies are sent to clients, rights advisors, patient representatives (if applicable), and the treatment team members. In the case of CTOs issued to clients in Stephenville or rural areas, the issuing psychiatrist maintains the CTO checklist. In the case of CTOs issued to ACT team clients, the checklist is kept and updated at the ACT offices. If CTOs or CTO documentation is issued/renewed in the community, original documentation is kept with the issuing psychiatrist in the community and copies are sent to the patient, patient representative, rights advisor, administrator, and treatment team members (ACT team members or the case managers).

Within Central Health, all CTO documentation, including the checklist, is kept at the ACT office. Within Labrador-Grenfell Health, each member of the treatment team receives a copy of the CTO and treatment plan and the checklists are kept by the case managers.

In discussions about documentation, respondents identified two challenges related to 1) documentation and communication of everyday activities and 2) documentation and distribution of CTO forms. With regard to documentation of everyday activities, participants noted that the fact that community workers and hospital based health care professionals use separate documentation software (Meditech and CRMS) can create challenges. Hospital workers cannot typically access information in CRMS and community workers may not be able to access information in Meditech. Treatment team members in the community indicated that it would be helpful if all community workers could view information in Meditech and all hospital workers could view information in CRMS. One ACT team member in St. John's gave an example of the type of dilemma that can be created when access is limited: in a situation where a client is in hospital and an ACT team member is paged at home, the ACT team member may be able to offer some information on the client's care, but likely wouldn't be able to provide detail and the hospital staff can't view client information in CRMS. This creates an information gap.

With regard to distribution and filing of CTO forms, some participants felt that there could be a risk that not everyone has easy access to the most up-to-date forms. CTO documentation is stored in different places within the health system, as different individuals keep or receive copies: the psychiatrist may have copies on file, the administrators receive copies, and treatment team members (ACT or case managers) receive copies. When new documents are issued (for example, a new CTO and a new plan), there is a risk that not everyone receives the new documentation. For example, a CTO may be renewed in the community, but the administrator may not receive documentation. To mitigate this risk, respondents suggested it could be useful to have centralized electronic documentation to which everyone has easy access.

3.5.4 Psychiatrists and Community Treatment Plans

In Western Health, a Clinical Nurse Specialist takes the lead in communicating with the treatment team about the treatment plan. In Eastern Health, this task may be completed by social workers on the inpatient psychiatric unit at the Waterford Hospital. Not all psychiatrists across the regions were aware

of all of the specific processes required to establish a treatment team; however, psychiatrists indicated they were aware of the needs that must be met and that the ACT team or rural case managers were essential participants on teams.

With regard to processes for making changes to a Community Treatment Plan, psychiatrists from Eastern Health indicated that in their understanding any amendment to a community treatment plan (such as a change in medication) required a new plan be written. Administrative file review within Eastern Health also indicated that new treatment plans were written for each new CTO issued to the same individual. Within Western Health, administrative file review and interviews suggested that not all psychiatrists filled out new plans with each community treatment order. In two cases within Western Health, CTOs were renewed without the issuance of a new Community Treatment Order (MHCTA-03) or a new Community Treatment Plan (MHCTA-04). Rather, these CTOs were renewed using a Certificate of Renewal (MHCTA-02), intended for renewing certifications issued under Section 17 of the Act.

3.6 CTO Processes and Legislative Requirements

A primary objective of the present review was to assess the issuance of CTOs to identify any variances between legislated requirements and current practices. The four specific areas reviewed included 1) assessment of the issuance and content of CTOs (3.8.1); 2) assessment of processes and practices surrounding mandatory reviews; 3) assessment of processes and practices related to expiry, termination, and revocation of CTOs and 4) assessment of processes and practices related to rights advisors.

3.6.1 Issuance of Community Treatment Orders

Main findings:

- This review identified 81 CTOs issued in the province from June 2014 to August 2016.
- In most cases in which legislative requirements for the issuance of CTOs were not met, it was because information included in the associated forms did not correspond to the information required by legislation.
- There are 15 instances overall in which variances between legislative requirements and practices may have been due to procedural irregularities.
- Procedural irregularities identified in this review included: three cases overall in which a community treatment plan was not developed or could not be located, six cases in which all required individuals may not have received copies of the CTO, five cases in which examination may not have taken place in the preceding 72 hours, and one case in which a CTO form required the psychiatrist to set out the facts on which the CTO was based and these facts were not provided.
- Adherence to legislative requirements has improved notably: of all CTOs issued in the province from April 2016 to August 2016, all legislative requirements were met, except for 2 cases in which checklists indicate that not all required individuals received copies of the CTO form.

The legislative requirements for issuing a CTO are defined in Section 40 of the Act while the requirements for the form and contents of CTOs are defined in Section 41 of the Act. To facilitate this review, access to all CTO documentation was requested from each of the four health authorities. According to documentation reviewed, a total of 81 CTOs were issued in the province between June 2014 and August 2016. To determine if the issuance of each CTO met legislative requirements defined in Sections 40 and 41 of the Act, each CTO form (MHCTA-03) was reviewed along with, CTO checklists (MHCTA-14) in cases where checklists were available. Tables 4, 5, 6, and 7 show results of this document review, with a focus on selected key legislative requirements. In instances coded as “yes”, documentation clearly indicated that the CTO had met the requirement. In instances coded as “no”, available documentation indicates the CTO did not meet the given requirement. In instances coded as “unknown”, it was unclear from the provided documentation, whether a requirement was met.

Overall, in most cases in which legislative requirements for the issuance of CTOs were not met, it was because information required by the associated forms did not correspond to the information required by legislation. For example, the Act requires that the CTO form sets out the facts on which a CTO is based. Several CTOs issued in the period under review did not set out the specific facts on which the CTO was based, but these facts were not required by many versions of the form. In nearly all cases, however, where the form includes a space for psychiatrists to set out the facts on which a CTO is based, these facts

are provided. Following this and other issues identified with the forms, the CTO form was updated in March 2016.The current form collects all the information required by the Act.

While most variances between legislative requirements and practices surrounding the issuance of CTOs are due to problems with the forms, there were 15 instances overall in which variances between legislative requirements and practices may have been due to procedural irregularities:

- Within Eastern Health, there was one instance in which a CTO was issued, but a corresponding community treatment plan (required by the legislation) could not be located. There were also two instances in which CTO checklists indicated that that not all required individuals received copies of the CTO.

- Within Western Health, three CTOs issued during the period under review used a Certificate of Renewal (MHCTA-02) in place of a Community Treatment Order (MHCTA-03). In these three cases, it is unknown if examination took place within the immediately preceding 72 hours, as the MHCTA-02 form does not include any space to specify the time and date at which the examination took place. In two of the instances in which an MHCTA-02 form was used, a community treatment plan could not be located. Additionally, there were two CTOs issued within Western Health during the period under review for which the checklist associated with the CTO indicates that copies were not provided to all required individuals. In all but one case in which the form requires the psychiatrist to set out the facts on which the CTO is based, these facts have been described.

- Within Labrador-Grenfell Health, there were four instances whereby legislative requirements were not met due to procedural error. In two instances noted in Table 7, the listed date of examination and the listed date of signatures are more than 72 hours apart, indicating that examination did not take place within the immediately preceding 72 hours. As well, examination of CTO checklists showed two instances in which rights advisors may not have been provided with copies of CTO forms.

From April 2016 to August 2016, there was notable improvement regarding adherence to legislative requirements (Table 8). Of all CTOs issued in the province during this period (N=11), all legislative requirements were met, except for 2 cases in which checklists indicate that not all required individuals received copies of the CTO form.

While administrative file review has identified some cases in which not all individuals received copies of the CTO form, processes are currently in place to ensure notifications take place and individuals receive copies of appropriate forms. In Eastern Health, the nurse in charge ensures individuals have copies of the CTO and plan and the current CTO checklist also assists. In Western Health, the checklist also assists and notes on the checklist often include an indication of how individuals were provided copies of the appropriate forms (“email scanned” or “registered mail” may be written beside initials or checkmarks). In CRMS, notifications will be in nurses’ progress notes.

Table 4. CTO Adherence to Legislative Requirements, June 2014 to August 2016, Eastern Health (N=35)

Legislative Requirement	Section	Yes	No	Unknown
Examination has taken place within the immediately preceding 72 hours	40(2)(a)	35	0	0
A community treatment plan has been developed	40(2)(c)	34	0	1[a]
Persons and organizations named in the plan have been consulted and have agreed in writing to be part of the plan	40(2)(d)	6	0	29[b]
Copies provided	43	10	2[c]	23[c]
Signed by issuing psychiatrist	41(1)	35	0	0
Sets out facts on which CTO is based	41(2)(b)	21	14[d]	0
Identifies issuing and managing psychiatrist	41(2)(c)	35	0	0
Describes the community treatment plan	41(2)(d)	34[e]	0	1[f]
Contains notice in writing advising the patient of: The right to retain and instruct counsel without delay The right to meet with a rights advisor within 24 hours The right to apply to the board for a review of the CTO The functions and address of the review board	41(3)(a)(b)(c)	11	24	0

[a] For one CTO reviewed, no community treatment plan was found on file at the Waterford or ACT offices.

[b] In 29 cases, there is no requirement on the CTO form for team member signatures and no other indication that team members were consulted. In these cases, it is unknown if they were consulted and/or if they agreed in writing to be part of the plan.

[c] In 23 cases, there is no checklist and no indication if all required individuals have received copies; in two cases, checklists indicate that the patient, rights advisor, and administrator did not received copies of CTOs

[d] In 14 cases, the form did not include a requirement/space to outline the facts on which the CTO is based. In all cases where detailed grounds are required by the form, they have been completed.

[e] In all 34 cases, a copy of the community treatment plan (MHCTA-04) was in the same file as the CTO. In 16 of these cases, the community treatment plan was also briefly described on the form itself.

[f] In one case, no Community Treatment Plan could be located.

Table 5. CTO Adherence to Legislative Requirements, June 2014 to August 2016, Central Health (N=5)

Legislative Requirement	Section	Yes	No	Unknown
Examination has taken place within the immediately preceding 72 hours	40(2)(a)	5	0	0
A community treatment plan has been developed	40(2)(c)	5	0	0
Persons and organizations named in the plan have been consulted and have agreed in writing to be part of the plan	40(2)(d)	1	0	4[a]
Copies provided	43	2	0	3[b]
Signed by issuing psychiatrist	41(1)	5	0	0
Sets out facts on which CTO is based	41(2)(b)	2	3[c]	0
Identifies issuing and managing psychiatrist	41(2)(c)	5	0	0
Describes the community treatment plan	41(2)(d)	5[d]	0	0
Contains notice in writing advising the patient of: The right to retain and instruct counsel without delay The right to meet with a rights advisor within 24 hours The right to apply to the board for a review of the CTO The functions and address of the review board	41(3)(a)(b)(c)	1	4	0

[a] For four CTOs issued in Central during the period under review, there is no requirement on the CTO form for team member signatures and no other indication that team members were consulted. In these cases, it is unknown if they were consulted and/or if they agreed in writing to be part of the plan.
[b] For three CTOs issued in Central during the period under review, there is no checklist and no indication if all required individuals have received copies
[c] In three cases the form did not include a requirement/space to outline the facts on which the CTO is based. In two cases where detailed groups are required by the form, they have been completed.
[d] In all five cases, a copy of the community treatment plan (MHCTA-04) was in the same file as the CTO. In one of these cases, the community treatment plan was briefly described on the form itself.

Table 6. CTO Adherence to Legislative Requirements, June 2014 to August 2016, Western Health (N=35)

Legislative Requirement	Section	Yes	No	Unknown
Examination has taken place within the immediately preceding 72 hours	40(2)(a)	31	0	4[a]
A community treatment plan has been developed	40(2)(c)	33	0	2[b]
Persons and organizations named in the plan have been consulted and have agreed in writing to be part of the plan	40(2)(d)	12	0	24[c]
Copies provided	43	14	2[d]	19[e]
Signed by issuing psychiatrist	41(1)	35	0	0
Sets out facts on which CTO is based	41(2)(b)	20	15[f]	0
Identifies issuing and managing psychiatrist	41(2)(c)	35	0	0
Describes the community treatment plan	41(2)(d)	33[g]	0	2[h]
Contains notice in writing advising the patient of: The right to retain and instruct counsel without delay The right to meet with a rights advisor within 24 hours The right to apply to the board for a review of the CTO The functions and address of the review board	41(3)(a)(b)(c)	8	27	0

[a] For four CTOs issued in Western during the period under review, a Certificate of Renewal (MHCTA-02) form was used rather than a Community Treatment Order (MHCTA-03). In these three cases, it is unknown if examination took place within the immediately preceding 72 hours.
[b] In two cases, a community treatment plan could not be located. In both cases, a Certificate of Renewal (MHCTA-02) form was used rather than a Community Treatment Order (MHCTA-03).
[c] In 23 cases, there is no requirement on the CTO form for team member signatures and no other indication that team members were consulted. In these cases, it is unknown if team members were consulted and/or if they agreed in writing to be part of the plan.
[d] In two cases, the checklist associated with the CTO indicates that copies have not been or may not have been provided to all required individuals.
[e] In nineteen cases, there is no checklist and no indication if all required individuals have received copies
[f] For 14 CTOs issued in Western, there is no space/requirement to outline the specific facts on which the CTO is based. For one CTO, there is a space for detailed grounds, but none are filled in. In 17 cases, there is a space for detailed grounds/facts on which the CTO is based and this space is filled out by the issuing psychiatrist. In three cases, an MHCTA-02 (Certificate of Renewal) has been used and detailed grounds are listed on this form.
[g] In 33 cases, a copy of the community treatment plan (MHCTA-04) was in the same file as the CTO. In 19 of these cases, the community treatment plan was also briefly described on the CTO itself.
[h] In two cases, a community treatment plan could not be located.

Table 7. CTO Adherence to Legislative Requirements, June 2014 to August 2016, Labrador-Grenfell Health (N=6)

Legislative Requirement	Section	Yes	No	Unknown
Examination has taken place within the immediately preceding 72 hours	40(2)(a)	4	2[a]	0
A community treatment plan has been developed	40(2)(c)	6	0	0
Persons and organizations named in the plan have been consulted and have agreed in writing to be part of the plan	40(2)(d)	1	0	5[b]
Copies provided	43	0	2[c]	4
Signed by issuing psychiatrist	41(1)	6	0	0
Sets out facts on which CTO is based	41(2)(b)	3	3[d]	0
Identifies issuing and managing psychiatrist	41(2)(c)	6	0	0
Describes the community treatment plan	41(2)(d)	6[e]	0	0
Contains notice in writing advising the patient of: The right to retain and instruct counsel without delay The right to meet with a rights advisor within 24 hours The right to apply to the board for a review of the CTO The functions and address of the review board	41(3)(a)(b)(c)	1	5	0

[a] In the case of two CTOs, the listed date of examination and the listed date of signatures are more than 72 hours apart

[b] In five cases, there is no requirement on the CTO form for team member signatures and no other indication that team members were consulted. In these cases, it is unknown if they were consulted and/or if they agreed in writing to be part of the plan

[c] In two cases, copies of the checklist indicate that rights advisors may not have received copies of the CTO; in 4 cases, there is no checklist and no indication if all required individuals have received copies

[d] In three cases, the form did not include a requirement/space to outline the facts on which the CTO is based. In all cases where detailed groups are required by the form, they have been completed.

[e] In the case of all six CTOs, a community treatment plan (MHCTA-04) was located in the same file as the CTO. In two of these instances the community treatment plan was also described on the CTO itself.

Table 8. CTO Adherence to Legislative Requirements, April 2016 to August 2016, All Health Regions (N=11)

Legislative Requirement	Section	Yes	No	Unknown
Examination has taken place within the immediately preceding 72 hours	40(2)(a)	11	0	0
A community treatment plan has been developed	40(2)(c)	11	0	0
Persons and organizations named in the plan have been consulted and have agreed in writing to be part of the plan	40(2)(d)	11	0	0
Copies provided	43	9	2[a]	0
Signed by issuing psychiatrist	41(1)	11	0	0
Sets out facts on which CTO is based	41(2)(b)	11	0	0
Identifies issuing and managing psychiatrist	41(2)(c)	11	0	0
Describes the community treatment plan	41(2)(d)	11	0	0
Contains notice in writing advising the patient of: The right to retain and instruct counsel without delay The right to meet with a rights advisor within 24 hours The right to apply to the board for a review of the CTO The functions and address of the review board	41(3)(a)(b)(c)	11	0	0

[a] In 2 cases, CTO checklists indicated that not all required individuals received copies of CTOs

3.6.2 Mandatory Reviews

> **Main findings:**
>
> - Mandatory reviews did not take place consistently prior to April 2016.
> - The current CTO checklist is structured to support the completion of mandatory reviews and there is evidence to suggest the review process has improved.
> - The development of a central CTO database could further support the completion of mandatory reviews.

Mandatory Reviews are addressed under Section 53 of the Act, which states that a CTO must undergo review upon its first renewal and then on the occasion of each second renewal after that. Responsibility for ensuring a CTO undergoes mandatory review lies with the administrator in cases where the patient was involuntary when the CTO was issued and with the psychiatrist in cases where the patient was voluntary at the time the CTO was issued. An application for review is made by filling out a MHCTA-13 form and sending the application to the Review Board.

The Secretary to the Review Board tracks the dates that applications are received, the dates that reviews take place, and the outcome of the review process for each application/review. As part of this review, Review Board files were reviewed and cross-referenced with CTO files collected from each health authority to determine if mandatory reviews took place in accord with legislated timeframes. Key informants were also asked if mandatory reviews took place and who is responsible for ensuring mandatory reviews take place.

Managers and directors from Eastern Health and Central Health indicated that managing psychiatrists are responsible for ensuring that mandatory reviews take place – though in both regions, psychiatrists receive some support with this process. In Eastern Health, informants noted that in practice, it is typically the psychiatrist's nurse who reviews the checklist and sends the application for review. Within Central Health, respondents indicated that the psychiatrist works with the Regional Manager of Mental Health and Addictions to ensure applications for review are completed. Managers and directors from Western Health noted that in current Western Health policy, the role of notifying the Review Board has been given to inpatient and community-based nurses. In Labrador-Grenfell Health, case managers review the checklist and initiate reviews.

While the role of initiating reviews has gone to nurses and case managers, psychiatrists are responsible for ensuring reviews take place under the Act. Some psychiatrists interviewed for this review were unaware of this responsibility. Psychiatrists in Eastern Health (who also typically manage patients from the Labrador-Grenfell Health Region) did not describe a process for ensuring reviews took place. Psychiatrists in Western Health noted that they typically schedule appointments for two weeks before

CTOs expire and fill out review forms at that time. No psychiatrists from Central Health were available for this review.

While some key informants noted that reviews may not have consistently taken place prior to 2016, respondents across the regions indicated that the review process has been improved, that the updated checklist has simplified the process and that since April 2016, required mandatory reviews have taken place.

To determine the number of mandatory reviews that took place over the period covered by this review, the dates of CTO issuance on forms provided by the regional health authorities were reviewed along with files provided by the Review Board that indicated dates that mandatory reviews took place. While this was the primary method available to determine if mandatory reviews were required (and took place) there were three central limitations to this method. First, because documentation has not always been issued to indicate if or when CTOs are terminated, and because the spaces for dates of original issuance and renewal at the top of the CTO form (see Appendix A) are used inconsistently,[1] it is unknown in the case of any CTO examined if it is/was a renewal or a new CTO (re-issued, for example, after a period in hospital). For the purposes of this review, a CTO was assumed to be a new CTO (assumed to be issued after a previous CTO had been cancelled) if it was issued fewer than four months after a previous CTO. For example, if a CTO was issued on January 1, 2015, and a new CTO was issued before May 1, 2015, it was assumed that the January 1, 2015, CTO had been revoked or terminated and a new CTO had been issued. A CTO was coded as a renewal if it was issued anywhere from four to six months after a previous CTO. For example, if a CTO was issued on January 1, 2015, and a new CTO was issued anywhere from May 2, 2015, to July 1, 2015, the CTO was assumed to be a renewal of the January 1 CTO (in the absence of any evidence, such as a notification of expiry or termination that the January 1 CTO had been cancelled). Second, because the review covered only a specified time period – June 2014 to August 2016 – it was not possible to determine if CTOs issued from June 2014 to November 2014 were new CTOs or renewals and thus, in these cases, not possible to determine if reviews were required. Finally, in any case in which CTO documentation is incomplete (i.e. in a case where a CTO form is missing/was not provided), it was not possible to determine if reviews are required as the requirement for mandatory review at issuance of a CTO is linked to the chronology of CTOs issued prior.

Given the limitations noted above, administrative file and document review determined that 15 reviews were required to take place across the province from June 2014 to August 2016. In all, six of these required reviews actually took place. A focused review of files active from April 2016 to August 2016 determined that of two reviews that were required to take place during the period, both took place.

[1] There are four fields at the top of each CTO form (MHCTA-03, refer to Appendix A) labeled "First CTO date," "Renewal Date," "Issue Date of Previous CTO," and "Expiry Date of Previous CTO." In the case of the field "First CTO date," this field appears to be filled in sometimes with the date of the first ever CTO and sometimes with the date of the first CTO since the last termination or expiration. In the case of "Renewal date," this field appears sometimes to be filled in with the date of the current renewal (the current CTO), sometimes with the renewal date of the previous CTO, and sometimes with the date of renewal of the current CTO. In the case of "Expiry date of previous CTO," this field is sometimes filled in with the actual expiry date of the previous CTO and sometimes with the date a previous CTO was (presumably) revoked or terminated. In many cases, some or all of the fields are left blank.

Table 9. Number of Mandatory CTO Reviews Required and Number of Mandatory CTO Reviews that took place, June 2014 to August 2016

	June 2014-August 2016		April 2016-August 2016	
Health Authority	Required	Actual	Required	Actual
Eastern/Labrador-Grenfell	10	5	2	2
Central	1	0	0	0
Western	4	1	0	0
Total	15	6	2	2

Key informant interviews indicated that when it became apparent that not all required reviews had taken place in early 2016, the chair of the Review Board called for reviews of CTOs in the province. Following this review, the chair held education sessions with psychiatrists focused on review requirements. The chair also notified the Department of Health and Community Services that not all reviews were being undertaken. Following this notification, an updated checklist was added to the standard forms required to implement a CTO (see Appendix A). The checklist is structured to support psychiatrists and nurses in identifying the times at which mandatory reviews are required.

With regard to engagement and effectiveness of the Review Board, key informant discussion indicated that the engagement of the review board depends on whether or not mandatory reviews are being undertaken. When the Review Board is involved in the review, board members are well engaged in the process. Key informant results indicated that the Review Board runs effectively, that all panel members are engaged and involved in decisions, and timeframes are typically met.

While many informants felt the updated CTO checklists were helpful, some respondents also suggested that the creation of a central and regularly monitored database for CTOs could also help to ensure all reviews take place. As one informant noted, in many cases client medical files may be thick and it may be a difficult or overlooked task to go through the file to determine when the next review needs to be undertaken. A central registry may be particularly important in cases where CTOs are issued by private psychiatrists. In cases where the psychiatrist is private, and where there is no oversight of the CTO by any central authority, it may be less likely that the review process will be enacted within legislated timeframes, or at all.

3.6.3 Apprehension Orders, Revocations, and Terminations

Main findings:

- Apprehension orders are typically issued when a client cannot be located to administer medication.
- It is possible that police (particularly RCMP) have been involved in client transport and/or conveyance for assessment or medication administration without the issuance of a formal apprehension order.
- There may be some lack of clarity about instances in which a notice of termination is required.
- There may be some lack of clarity about who is responsible for filling out a notice of termination.

3.6.3.1 Apprehension Orders

Under Section 51 of the Act, a psychiatrist can issue an order for a peace officer to apprehend and convey a CTO client to a facility named in the order for involuntary assessment, provided the following conditions are met: the psychiatrist must have reasonable grounds to believe the criteria for a CTO continue to be met; the client refuses to submit to a voluntary assessment; reasonable efforts have been made to inform the client that they have failed to comply with the CTO and that the psychiatrist may issue an order for involuntary assessment; and reasonable assistance has already been provided to the client to comply with the CTO. A psychiatrist can issue an order of apprehension by filling out an Order for Apprehension, Conveyance, and Examination (MHCTA-08). Once an order of apprehension has been issued, the order gives a peace officer the authority to apprehend the individual named in the order and detain and control the individual during conveyance to a named facility. Once the client has been conveyed to a facility, within 72 hours after arrival, a psychiatric assessment must be performed to determine if a) the community treatment order should be terminated and the person should be released without being subject to the order, b) the community treatment order should be continued with any necessary variations, or c) the community treatment order should be revoked and a first certificate of involuntary admission issued.

This review identified a total of 16 apprehension orders issued for CTO clients across the province – six in Eastern Health, one in Central Health, seven in Western Health, and two in Labrador-Grenfell Health. While the *Mental Health Care and Treatment Act Provincial Policy and Procedures Manual* indicates that a copy of all CTO-related forms (including apprehension orders) be provided to the administrator, it is possible that there may be some apprehension orders that were not located for this review.

Managers and directors from across the regions agreed that apprehension orders are issued when a client fails to adhere to one or more components of the community treatment plan. While failure to adhere to the plan could involve missing appointments or deterioration for unknown reasons, most often, apprehension orders are issued when a client cannot be located to administer medication. Managers and directors noted that before an apprehension order is issued, efforts will be made to assist the client in complying with the CTO. Some psychiatrists indicated that before issuing an apprehension order, the ACT team will attempt to find the client two or three times. When asked what happens when an apprehension order is issued, psychiatrists from Eastern and Western Health noted that they fill out an apprehension order and send it to police. Police will then convey the client for assessment and the psychiatrist will typically either administer medication and send the client home or admit the client.

While psychiatrists interviewed for this review noted that client apprehension and conveyance required them to complete a MHCTA-08 form and send it to police, it is possible that police (particularly RCMP) have been involved in client transport and/or conveyance for assessment or medication administration without the issuance of a formal apprehension order. Interview data suggests that there may be some misunderstanding about whether an apprehension order is needed for police to convey clients to hospitals or clinics for assessment. Treatment team members from Central Health, for example, relayed a psychiatrist's frustration that the local RCMP would not transport a CTO client to hospital "without paperwork" and noted that when looking for assistance with clients, "it can depend who's on a shift … some [RCMP officers] will be happy to assist, with others it's more of a process." RCMP and RNC officers interviewed for this review on the other hand, indicated that routine use of RCMP or RNC for transport or conveyance is inappropriate. RNC contacts emphasized that the RNC has no legal ability to apprehend an individual on a CTO without an apprehension order issued on the approved form.

Asked further about their experiences with apprehension, the RCMP informant indicated that multiple apprehensions of the same individual can lead to increased aggression with each apprehension. However, RNC informants indicated that the process of apprehending individuals subject to CTOs tends to go very smoothly because health care workers who have requested apprehension tend to be responsive and waiting for the individual when RNC arrive at the hospital. In other cases, where RNC convey individuals under Section 20 (which requires only that the peace officer has reasonable grounds to believe that the individual has a mental disorder, but does not require health care workers to request the call) – officers may wait for some time at the hospital before a health care professional is able to assist.

As the priority is to locate and convey the individual, RNC and RCMP informants indicated that there is no way to locate and convey privately. RNC or RCMP officers may have to ask family and friends to help locate the individual, which is necessary, but compromises privacy. Once an individual is conveyed, there is no separate entrance at the Waterford Hospital, and therefore no way to privately convey – though the Waterford Hospital does have a short stay unit where individuals can be conveyed. In rural areas where hospitals have no safe rooms and no short stay unit, individuals are taken in through emergency and officers wait with the individual. While this can compromise privacy, without safe rooms, there are presently no other options for detention.

3.6.3.2 Termination and Revocation

In accord with the Act, CTOs can be terminated or revoked in three situations, described in Sections 47, 50, and 51:

- **Section 47** indicates that when a community treatment order **expires** and is not renewed, written notice that the order is no longer in effect shall be provided to the person who is subject of the order, his or her representative, the rights advisor, and each health care professional, person, or organization named in the plan.

- **Section 50** indicates that a psychiatrist may at any time and shall at the request of the person subject to the CTO conduct an assessment to determine if the individual still meets the criteria for a CTO or if the individual can live in the community without being subject to the CTO. **If it is determined the CTO is no longer necessary, the psychiatrist shall terminate the order** and provide notice, on the approved form, to the person subject to the order, the administrator, the person's representative, the rights advisor, and each health care professional, person and organization named in the plan.

- **Section 51 describes the conditions under which an individual can be involuntarily conveyed by a peace officer to a health facility for assessment, the outcome of which may be termination or revocation of the CTO.** Within 72 hours of arrival at the health facility, the individual must be assessed and a determination must be made as to whether a) the community treatment order should be terminated and the person should be released without being subject to the order, b) the community treatment order should be continued with any necessary variations, or c) the community treatment order should be revoked and a first certificate of involuntary admission issued.

Notably, the legislation explicitly requires written notice when a community treatment order is terminated because a psychiatrist no longer deems it necessary (under Section 50) or when it expires (under Section 47). However, the legislation *does not require a notice of termination when a CTO is revoked under Section 51* (i.e. when an individual is apprehended and admitted).

Regarding the process for revoking a CTO in their regions, managers and directors pointed to the importance of filling out the proper paperwork, including a notice of termination (Notification Advising a Person that a Community Treatment Order is No Longer in Effect – MHCTA-07) when a CTO is revoked, however, some respondents indicated that there has been confusion among team members in the past regarding the proper paperwork with respect to revocation and termination. With regard to process, psychiatrists from both Eastern and Western Health also noted that in any case where termination or revocation occurs, a formal notification is given or sent to the patient. Reasons noted by psychiatrists for terminating, revoking, or cancelling a CTO included involuntary hospitalization or client recovery/improvement.

While managers, directors, and psychiatrists underlined the requirement to issue a notification when a CTO is terminated, in interviews, some treatment team members from both Eastern and Western Health were unsure about when written notice of termination is required. Treatment team members from Eastern Health noted that, in the past, there was an understanding among staff that when an individual on a CTO is involuntarily admitted (and the CTO is revoked), a notice of termination is not required. This is in fact consistent with Section 51 of the Act, however, key informants indicated that after the most recent review, the protocol was changed and it is now understood that a MHCTA-07 form is filled out when CTOs are revoked due to involuntary admission. It was not clear to some treatment team members who is responsible for filling out a notice of termination in these circumstances. Similar to respondents in Eastern Health, some treatment members in Western Health were also unsure about when a notice of termination is required and who is responsible for filling these notices out.

Administrative file review also suggests that there may be lack of clarity about legislative requirements regarding notification that a community treatment order is no longer in effect. This manifested in the file review in two ways. First, there is some evidence to suggest that notices of termination are not consistently issued when CTOs expire. There were 19 cases across the province where CTOs may have expired, but only two cases in which notices of termination/expiry were issued to clients. It is, however, not possible to determine precisely how many CTOs expired from June 2014 to August 2016 because notification is not required when clients on CTOs are admitted to hospital and their CTOs are revoked. Thus, within the context of the file review, a CTO that may appear to have expired (i.e. a CTO is issued, no CTO is issued subsequently, and no other documentation is found), may actually have been revoked without documentation. The previously noted count of 19 expired CTOs is based on the assumption that when a CTO is issued, no CTO is subsequently issued, and there is no notice that the CTO has been revoked, then the assumption can be made that the CTO expired.

Table 10 provides counts of the number of CTOs cancelled and reissued due to unknown reasons, the number of CTOs cancelled due to problems with the CTO itself, and the numbers of notices of termination completed in each case. There were 14 instances overall in which CTOs were cancelled and reissued within four or fewer months of issue of the previous CTO. In one of these instances, a Notification Advising a Client that a CTO is No Longer in Effect was issued to the client. Additionally, 18 CTOs were cancelled and reissued due to problems with the CTO.[2] Notifications Advising a Client that a CTO is No Longer in Effect were issued in 9 of these instances.

[2] Information from key informant interviews indicated that a number of CTOs were cancelled and reissued in March 2016 due to procedural irregularities/problems the issuance of CTOs. This was confirmed in file review, which showed that several CTOs were cancelled and reissued in March 2016. CTOs were coded as canceled due to problems with the CTO itself if they were canceled and reissued in March 2016 and fewer than four months after issuance of the previous CTO.

Table 10. Total Number of CTOs Cancelled and Total Number of Notifications Advising a Client that a CTO is No Longer in Effect, June 2014 to August 2016

RHA	Total CTOs Reviewed	Total CTOs Cancelled and Re-issued (<4 months)	MHCTA-07 Issued for cancelled and Re-issued CTOs	Total CTOs cancelled due to problems with CTO	Total MHCTA-07 issued for CTOs cancelled due to problems with CTO
Eastern	35	7	0	7	4[a]
Western	35	3	1	9	3[b]
Central	5	1	0	0	0[c]
Labrador-Grenfell	6	3	0	2	2[d]
Total	81	13	1	19	9

[a] A total of seven MHCTA-07 forms were located in Eastern Health over the time period noted. Four were issued due to problems with the CTO itself, two appear to have been issued with no CTO being re-issued, suggesting the client improved or was still in hospital at the date of this review, and one was issued for an expired CTO.

[b] A total of eight CTO MHCTA-07 forms were located in Western Health over the time period reviewed. One appeared to be written for a CTO that was cancelled and later re-issued and three appeared to be written for CTOs that were cancelled due to problems with the CTO itself. An additional four MHCTA-07 forms were filled out for CTOs that were not subsequently re-issued, suggesting the client improved and was no longer in need of a CTO or was still in hospital at the time this review was completed.

[c] No MHCTA-07 forms were issued to clients in Central Health during the period under review.

[d] A total of two CTO MHCTA-07 forms were filled out for clients in the Labrador-Grenfell Health Region – both were filled out in cases where the CTO was cancelled due to problems with the CTO.

3.6.4 Rights Advisors

Main findings:

- Telelink received notifications that clients had been placed on CTOs in 26/81 or 32% of cases from June 2014 to August 2016. Rights advisors made contact with CTO clients within the required timeframe of 24 hours in 28/81 or 35% of cases from June 2014 to August 2016.
- In 16 cases in which clients were placed on CTOs, records of Telelink notifications indicated only that clients had been decertified; in 17 cases, rights advisors logs for the day a CTO was issued indicated only that clients had been discharged or decertified.
- Rights advisors made follow-up contact with CTO clients within the required timeframe of 10 days in 27% of cases from June 2014 to August 2016
- Processes regarding notification and follow-up have improved: from April 2016 to August 2016, notifications to Telelink that clients had been placed on CTOs were made in 8/11 or 72% of cases. During the same time period, Rights advisors made contact with CTO clients within 24 hours of being placed on a CTO in 10/11 or 91% of cases.
- Rights advisors made follow up contact with CTO clients within 10 days of being placed on a CTO in 70% of cases from April 2016 to August 2016.

Regulations and responsibilities related to rights advisors are addressed in Sections 13, 14, and 15 of the Act. Section 13 indicates that a rights advisor may not be a person involved in direct clinical care or supervision of the person to whom rights advice is given. Section 14 indicates that the rights advisor shall meet (in person or by other means) with the client within 24 hours and again within 10 days of becoming an involuntary patient or being issued a community treatment order. The requirement of rights advisors to meet with clients within 10 days (in addition to the 24 hour follow up period) was a recommendation from the 2012 review. This recommendation was implemented and was included in a legislative amendment in June 2014.

The function of the rights advisor is to explain to clients, and patient representatives when appointed by the individuals subject to a CTO, the significance of the involuntary admission or community treatment order and provide any requested assistance in making application to the Review Board for review or obtaining legal counsel. Rights advisors shall also, at the request of the client, accompany clients to board hearings. Section 15 notes that the administrator or attending psychiatrist, as appropriate, shall ensure the rights advisor is given notice of the issuance, renewal, expiry, termination, or revocation of a community treatment order and/or an application to the Review Board. Rights advisor roles are limited to rights advice and do not extend to advocacy.

There is one rights advisor working in Western Health, one working in Central Health, and two working in Eastern Health. Rights advisors for Eastern Health also cover Labrador-Grenfell patients. The process for notification of the rights advisor of the issuance of a CTO is as follows: once a CTO is issued, an individual from the hospital (nurse, psychiatrist, social worker) will typically contact Telelink (a telephone messaging service) to inform that a CTO has been issued and provide the date and time it was issued. Telelink calls the rights advisor at 10:00am, 1:00pm, 4:00pm, and 7:00pm each day to relay messages to the rights advisor. Once the rights advisor receives notification that a CTO has been issued, the rights advisor will attempt to make contact with the individual subject to the CTO, and his or her patient representative if one has been named. If the first attempt is unsuccessful, the rights advisor will continue to try and reach the individual until contact has been made.

Prior to June 2016, rights advisors were required to record their workload in a log book which was turned over to the Department of Health and Community Services upon completion of the book. Log books were intended for recording information including when the rights advisor was notified by Telelink of the CTO as well as the rights advisor's attempts at contacting individuals with CTOs. In June 2016, the protocol for recording rights advisors' activities changed; log books were no longer used and instead, the Department of Health and Community Services developed workload documentation forms for rights advisors to complete. The forms are client-based and rights advisors are required to indicate when they received notification for each client, and by whom, the date and time the client was issued a new or renewed CTO, the expiry or revocation of a CTO, or any change in the client's status, when it was called in by regional health authority staff, as well as every attempt and successful contact made with the client and his or her patient representative.

To examine the process of rights advisor notification and follow-up, both Telelink records and rights advisors' records were reviewed. In the case of rights advisor records, rights advisor log books and the Department of Health and Community Services forms were audited and cross referenced with CTOs issued from June 2014 to August 2016 to determine whether and how often rights advisors had made contact with clients within 24 hours of being placed on a CTO and again within 10 days of being placed on a CTO. Because there was no standard way that log book entries were made from June 2014 to June 2016, a coding system was employed for review of the log books: in some instances rights advisors clearly indicated they had made contact with the patient within 24 hours or 10 days (Example: "Spoke with X, explained rights"). These instances were coded as 24 hour (or 10 day) contact. In other instances, the rights advisor may have included information that suggests it is possible contact was been made (Example: "X was issued CTO, called ACT team for info on X"). These instances were coded as possible 24 hour (or 10 day) contact. Finally there were also instances in which on the same day(s) that administrative file review showed that CTOs were issued, rights advisor log books included a note that a patient was made voluntary or decertified. These instances were coded as "Voluntary/Decertified." Instances in which there were no entries regarding a particular CTO clients in any log books on the day the client's CTO was issued were coded as "No 24 hour (or 10 day) contact." Table 11 shows the results of this review.

Table 11. Confirmed and Possible 24 hour and 10 day contact with Rights Advisors for Clients Issued CTOs from June 2014 to August 2016

Regional Health Authority	Total CTOs	24 hour contact	Possible 24 hour contact	Voluntary/ Decertified	No 24 hour contact	10 day contact	Possible 10 day contact	No 10 day contact
Eastern	35	13	8	6	8	10	0	23[a]
Central	5	3	0	2	0	2	0	3
Western	35	11	1	9	14	10	0	25
LGH	6	1	0	0	5	0	1	5
Total	81	28	9	17	27	22	1	56

[a] Within Eastern, there were 2 instances in which no 10 day contact was made, however, administrative records and/or log books indicate that in both cases, the client returned to hospital or was issued a new CTO before 10 days had passed. Both of these cases were excluded from tabulations for 10 day contact.

During the period under review, there were a number of instances in which 24 hour or 10 day contact was not made. There were also 17 total instances in which it appears there was miscommunication and a rights advisor was notified (or misunderstood) that a patient was decertified or made voluntary, but was not notified (or understood a message incorrectly) that the patient was issued a CTO.

Table 12 shows the results of administrative file/log book review from April 2016 to August 2016. Results indicate notable improvement in 24 hour and 10 day follow up.

Table 12. Confirmed and Possible 24 hour and 10 day contact with Rights Advisors for Clients Issued CTOs from April 2016 to August 2016

	Total CTOs	24 hour contact	Possible 24 hour contact	Voluntary/ Decertified	No 24 hour contact	10 day contact	Possible 10 day contact	No 10 day contact
Eastern	5	4	1	0	0	3	0	1[a]
Central	1	1	0	0	0	1	0	0
Western	4	4	0	0	0	3	0	1
LGH	1	1	0	0	0	0	1	0
Total	11	10	1	0	0	7	1	2

[a] One CTO issued in Eastern from April 2016 to August 2016 was cancelled and reissued before 10 days had passed. This CTO was not included in tabulations regarding 10 day follow up.

To explore the process of notifications to Telelink, Telelink records were reviewed. Call records were requested from Telelink and records were then reviewed to determine 1) if notification to Telelink took

place when the CTO was issued or any time in the two week period after the CTO was issued and 2) the content of the notification. To determine the content of the notification, the “Patient Status” as relayed to the Telelink operator was reviewed along with any additional message(s) provided to the Telelink operator to pass on. Results were coded into four categories (Table 13). In cases where Telelink records indicate that a notification was made on the date a CTO was issued and either the field “Patient Status” or the message provided to the Telelink operator (or both) indicated that the client had been placed on a CTO, the case was coded as “Telelink Notification (CTO).” In cases where Telelink records indicate that a notification was made on the date a CTO was issued, but there is no indication that a client has been placed on a CTO and either the “Patient Status” or the message(s) provided to the Telelink operator (or both) indicate that the client had been made voluntary or been decertified, the case is coded as “Telelink Notification (Voluntary/Decertified). In cases where Telelink records indicate that a notification was made on the date a CTO was issued and the “Patient Status” or the message(s) provided to the Telelink operator indicate something other than CTO issuance or decertification, the case is coded as “Telelink Notification (Other).” This category, for example, contains calls made on the day a CTO was issued that indicate that a client was certified or calls that contain no “Patient Status” or message. In some cases, Telelink records contain no notification(s) for the date a CTO was issued. These are shown in Table 13 in the column “No Telelink Notification”

In total, of 81 CTOs identified from June 2014 to August 2016, there were 26 instances in which calls to Telelink contained an indication that a client was issued a CTO (Table 13). In an additional 16 instances, calls to Telelink contained an indication only that the client had been made voluntary or decertified. In six instances, calls to Telelink indicated something other than CTO issuance or decertification and in 33 instances, Telelink records do not show any calls on the date(s) CTOs were issued for particular clients.

Table 14 shows the results of a review of Telelink records for CTOs issued from April 2016 to August 2016. Results indicate notable improvement and show that of 11 CTOs issued during this period, there were eight instances in which calls to Telelink indicated that a client had been placed on a CTO and three instances in which calls to Telelink indicated only that a client had been decertified.

It should be noted that there were some cases in which rights advisor records indicate that 24 follow-up occurred, but Telelink records do not indicate that notification to Telelink took place. Some explanation for this finding is provided by interview data. Interview data suggested that there may have been some cases (particularly in the early months of 2016) where rights advisors were present when CTOs were issued and therefore would not have required notification through Telelink.

Table 13. Telelink Notifications for Clients Issued CTOs, June 2014 to August 2016

Health Authority	CTOs	Telelink Notification (CTO)	Telelink Notification (Voluntary/ Decertified)	Telelink Notification (Other)	No Telelink Notification
Eastern	**35**	**13**[a]	**8**	**4**	**10**
Central	**5**	**3**[b]	**0**	**1**	**1**
Western	**35**	**8**[c]	**8**	**1**	**18**
LGH	**6**	**2**[d]	**0**	**0**	**4**
Total	**81**	**26**	**16**	**6**	**33**

[a] In Eastern, in all cases in which RHA calls to Telelink took place to notify that a client had been placed on a CTO, rights advisor records indicate that 24 hour follow-up was either definite or possible (see Table 11 above)

[b] In Central, in two out of three cases in which RHA calls to Telelink took place to notify that a client had been placed on a CTO, rights advisor records indicate that 24 hour follow-up occurred. In one cases, rights advisor logs recorded that the client was discharged.

[c] In Western, in six out eight cases in which RHA calls to Telelink took place to notify that a client had been placed on a CTO, rights advisor records indicate that 24 follow-up was definite or possible. In one case, rights advisor records indicate that 24 follow-up did not occur. In one case, rights advisor logs record indicate that the client was decertified.

[d] In LGH, in one of two cases in which RHA calls to Telelink took place to notify that a client had been placed on a CTO, rights advisor records indicate that 24 follow-up occurred. In the remaining case, rights advisor records indicate that 24 hour follow-up did not occur.

Table 14. Telelink Notifications for Clients Issued CTOs, April 2016 to August 2016

Health Authority	CTOs	Telelink Notification (CTO)	Telelink Notification (Voluntary/ Decertified)	Telelink Notification (Other)	No Telelink Notification
Eastern	**5**	**2**	**3**	**0**	**0**
Central	**1**	**1**	**0**	**0**	**0**
Western	**4**	**4**	**0**	**0**	**0**
LGH	**1**	**1**	**0**	**0**	**1**
Total	**11**	**8**	**3**	**0**	**0**

3.7 Client Experiences

Main findings:

- Current and former clients interviewed for this review felt that their CTO helped with their recovery
- Clients identified the assistance they received from the ACT team as a key benefit of their treatment plans

To help understand client experiences and insight into CTOs, current and former CTO clients were interviewed for this review. In all, four current or former CTO clients were interviewed – two clients from the Eastern Health region and two clients from the Western Health region. Interviews took place in person at the ACT offices (in Western Health) or at clients' residences (in Eastern Health). Clients were asked about their experience being on CTOs, whether it helped with their recovery, what worked well, and what improvements could be made.

When asked about their experience being on a CTO and if the CTO helped with recovery, all four clients interviewed indicated that the CTO helped with recovery. One client indicated specifically that they may not have taken medication if they had not been on a CTO. Another client, however, did note that they did not like the feeling that they were "forced" to take medication – however, this client, like the others, felt the CTO helped with recovery.

All four clients interviewed for this review were clear that the help they received from the ACT team was excellent and the connection was helpful to them. One client noted that meeting with members of the ACT team "helps keep me relaxed [and] gives me a break from the way I'm thinking." Another client explained how helpful it was to receive assistance with everyday activities.

None of the clients interviewed identified any improvements that could be made to CTOs though one client did note that the CTO made them feel as though their "freedom of choice is taken away." This client also noted, however, that "it could be good for some people as well."

3.8 Auditing Procedures

Main finding:

- Auditing or regular review processes for CTOs are in place within Eastern, Western, and Central Health. Within Labrador-Grenfell Health, case managers follow CTOs to ensure processes are being followed.

As part of this review, psychiatrists and regional health authority managers and directors were asked about any auditing processes in place for CTOs. Psychiatrists in Eastern Health – who typically manage clients from the Labrador-Grenfell Health region as well - did not indicate that they had a process for auditing CTOs. Psychiatrists from Western Health meet once a month to review all active CTOs.

In the past, CTOs within Eastern Health were reviewed yearly as part of a larger chart audit on certifications and Community Treatment Orders. The yearly audit used a checklist that was based on the legislation and focused on items such as notifications and timeframes. However, because there are a small number of CTOs issued every year, a very small number CTOs were included in larger audits. In early 2016, Eastern Health performed an audit specific to CTOs issued in the region. Based on the results of the review, Eastern Health has provided input into the CTO forms and developed an education module for staff specific to CTOs. Since the review, Eastern Health has established a committee to identify improvements to CTO processes. Moving forward, Eastern Health will plan one yearly audit for CTOs and one for certifications. There is also a nurse within the Clinical Efficiency Division who tracks CTOs.

Within Western Health, active CTOs are reviewed every month. Western Health also maintains a database for information on CTOs, including the CTO date of issue and the managing psychiatrist. This database allows the user to quickly determine how many CTOs are active at any one time as well as who is managing CTOs. Western Health has also completed an internal review. A key recommendation from the review was the need to develop specific policies regarding CTOs. As such, Western Health has begun to develop policies around issuance, failure to comply, and termination.

There is one CTO in place in Central Health. While it is required to undergo mandatory review by the Review Board every year, Central Health reviews the CTO every 6 months. Based on experience with CTOs, Central Health has also made recommendations regarding the CTO forms.

Within Labrador-Grenfell Health, case managers follow CTOs to ensure processes are being followed, but there is no specific auditing process in place.

3.9 Education and Support

Main findings:

- During the period June 2014 to August 2016, provincial education on CTOs was limited.
- Key informants suggested that there was a need for enhanced and regular education on CTOs across the province that is provincially directed and consistent across professions and organizations.

There is currently limited provincial education that specifically addresses CTOs. A monthly webinar, developed by Eastern Health covers the entire Act, but includes only a small section on CTOs. Eastern

Health has developed a separate module on CTOs. Western Health provides a training session on CTOs similar to that of Eastern Health. Eastern Health also provides education on the Act for medical residents – these education sessions include education on CTOs. A clinical educator is also available in Eastern Health to answer questions on CTOs

Central Health and Labrador-Grenfell Health did not identify any education sessions or efforts specific to CTOs. However, within Western Health, where the second highest number of CTOs in the province are issued, managers and directors noted that a high level of support is available to nurses involved in issuing CTOs. Respondents from Labrador-Grenfell Health noted that excellent support had been received from the Department of Health and Community Services with regard to CTOs.

Beyond general agreement on the need for enhanced/additional education on CTOs within the regions, a number of suggestions were common across several key informant interviews:

- CTO education should be provincially rather than regionally directed and should be consistent not just across regional health authorities, but across professions and organizations involved in administering and monitoring CTOs. A number of respondents, for example, relayed situations in which RNC or RCMP understanding of the Act differed from regional health authority staff understanding of the Act. A provincial education module may help to address these misunderstandings.

- Education should address the specific roles and responsibilities of everyone involved in administering and monitoring CTOs.

- Education should not only encompass the regulations found in the Act, but also address some specific situations: for example, if a nurse can't find a client and can't contact the managing psychiatrist to issue an order of apprehension, what is the next step?

- Education should occur at regular intervals to account for staff turnover and should begin with psychiatrists, as they have responsibility for managing CTOs under the Act.

In addition to enhanced education regarding CTOs, other suggestions from front-line workers and/or regional health authority managers and directors, and psychiatrists included a potential mechanism/process whereby all CTOs are reviewed by an expert (or the Review Board) before they are put in place and a number to call or provincial expert/coordinator who could provide guidance in specific situations or answer specific questions. One respondent suggested a flow chart which shows processes to be followed in specific situations could be helpful.

3.10 Summary of Key Findings

This review of CTOs issued under the *Mental Health Care and Treatment Act* was undertaken from September 2016 to February 2017. The review included interviews with 65 key informants from across the province, examination of 81 CTOs and their associated documentation (including CTO forms, Community Treatment Plans, Orders for Apprehension and Conveyance, Notices of Termination, Applications for Review, and CTO Checklists), examination of data from rights advisor logs, and examination of Board Review CTO data.

Utilizing a question framework produced by the Department of Health and Community Services in collaboration with the Provincial CTO Working Group, this review aimed to address four objectives:

Objective 1: To assess the issuance of CTOs by examining the process of the initial psychiatric assessment, completion of the CTO documentation, and development of the community treatment plan, in order to identify any variances between legislated requirements and current practices.

- CTOs are issued to avoid deterioration when clients leave the hospital, particularly when patients may be at risk of harm to themselves or others. In all, this review identified 81 CTOs issued across the province during the period under review.
- In most cases where the content of the community treatment order was not in accord with the content required by legislation, it was because the form did not require legislated information, however, there were 15 instances overall in which variances between legislative requirements and practices may have been due to procedural irregularities. For the 11 CTOs issued since April 2016, there were only two procedural irregularities.
- Notices of termination may not always be issued when appropriate. There may be some lack of clarity about when a notice of termination is required and who is responsible for filling out a notice of termination.
- Telelink records indicate that notifications were made to Telelink that a client had been placed on a CTO in 26/81 or 32% of cases from June 2014 to August 2016. From April 2016 to August 2016, Telelink records indicate the process of notification had improved with notifications that a client had been placed on a CTO in 8/11 CTOs issued in this period.
- There is evidence that rights advisors made contact with CTO clients within 24 hours in at least 28/81 or 35% of cases from June 2014 to August 2016, however, of 11 CTOs issued across the province from April 2016 to August 2016, there was only one case in which 24 hour contact with a rights advisor may not have occurred.

Objective 2: To assess the administration of CTOs, including an examination of how CTOs and community treatment plans are carried out by the treatment teams and other appropriate individuals.

- Treatment teams are typically led by ACT team members in urban areas or case managers in rural areas. Treatment teams may include family, nurses, community supports, family doctors, and RCMP.

- Treatment teams communicate often with each other and with clients, however, there may be room for more consultation with treatment teams in the initial development of community treatment plans.
- Challenges with regard to CTO implementation in the community included: finding suitable housing for CTO clients, transporting clients to hospital (in rural areas), and challenges accessing managing psychiatrists.
- Another challenge regarding the administration/implementation of CTOs involved miscommunication or misunderstanding among RNC/RMCP and health care professionals regarding the role of peace officers in the administration of CTOs.

Objective 3: To assess the effectiveness of the monitoring and oversight of CTOs, including a review of auditing and quality assurance activities which are undertaken by the regional health authorities.

- The Administrator in each region plays a key role in monitoring and oversight of CTOs as the administrator is supposed to receive a copy of all CTO-related documents issued in the region. One challenge in this regard is that there is nothing in the Act to compel psychiatrists to send copies of CTOs or associated forms to the administrator and no way for administrators to be sure they have files on all individuals detained in the community.
- The Review Board operates as another key oversight mechanism, however, prior to April 2016, all required reviews were not undertaken. There is evidence to suggest that the review process has improved, however, interviews with psychiatrists also indicated some lack of clarity about responsibility for ensuring reviews take place.
- While many informants felt the updated CTO checklists were helpful to CTO oversight and to ensuring reviews take place, some respondents also suggested that the creation of a central and regularly monitored database for CTOs could also help to ensure all reviews take place.
- Auditing or regular review processes for CTOs are in place within Eastern, Western, and Central Health. Within Labrador-Grenfell Health, case managers follow CTOs to ensure processes are being followed.

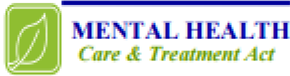
Objective 4: To assess the quality assurance practices in place to ensure the legislation is reflective of best practices and patient needs.

- Key informants felt that the legislation was generally clear, however, some psychiatrists felt that the requirement for three involuntary hospitalizations in the last two years before a CTO can be issued was too restrictive. These informants felt some patients would be better served if psychiatrists could issue a CTO after one or two hospitalizations, if it was judged to be clinically necessary.
- The deterioration clause was identified as useful because it allows clinicians to take action to prevent patients from becoming unwell.
- While each region described regular review processes or indicated CTOs are followed by case managers to ensure processes are followed, there was also a clear need for enhanced education

on CTOs across the province. Key informants suggested that education should be provincially directed and consistent across professions and organizations.
- Current and former clients interviewed for this review felt that their CTO helped with their recovery.

While some of the findings reviewed above show that there were procedural irregularities that occurred throughout the review period, it is also notable that practices have improved since April 2016, in particular with regard to adherence to legislative requirements regarding the CTO form as well as requirements related to rights advisors. There may still be room for more communication regarding specific roles and responsibilities of all of the individuals and organizations involved in the administration and implementation of CTOs. Moving forward, enhanced auditing practices and additional education on CTOs can help to ensure that understanding and practices related to CTOs reflect legislation. Efforts to enhance practices regarding CTO administration, education, and auditing are already underway at both regional and provincial levels; the findings of this review can help to guide these efforts.

Appendix A: Mental Health Care and Treatment Act Associated CTO Forms (September 2016)



Department of Health & Community Services
Mental Health Care and Treatment Act
Section 41(1)

PLEASE PRINT LEGIBLY

COPY: ☐**Original (must go in file)** ☐**Patient** ☐**Patient Representative** ☐**Rights Advisor**
☐**Administrator** ☐ **Treatment Plan Member:** ______________________

Community Treatment Order

First Community Treatment Order (CTO) Date: ____________ Renewal Date: _____________

Issue Date of previous CTO: _____________ Expiry Date of previous CTO: _____________

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 & 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 have probable cause to believe that the person should be subject to a community treatment order based on the following grounds (*be specific in setting out the grounds*):
____
____
____
____
____
____
____
____
____

Policy #1.30.30 **Page 1 of 6** **MHCTA-03**

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.

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

____ 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 considering 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 considering 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.

I ______________________________ have issued this order and am responsible for its
(psychiatrist)
general supervision and management. A community treatment plan (attached) under the general supervision and management of ______________________________ has been
(please print name of person responsible for plan)
developed for the subject and is described as follows:
____
____
____
____
____
____

Policy #1.30.30 **Page 2 of 6** **MHCTA-03**

The health professional, persons and organizations who have agreed to provide treatment and support services under the plan include:

Signature of Managing Psychiatrist	*Signature of Treatment Team Member*
Signature of Treatment Team Member	*Signature of Treatment Team Member*
Signature of Treatment Team Member	*Signature of Treatment Team Member*

Date	***Signature of Examining Psychiatrist***

RIGHTS OF A PERSON SUBJECT TO A CTO

Section 2. Notice of rights 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 Review Board, at your request;
   - Assist you in obtaining legal counsel, at your request;
   - Attend at 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 facility.

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 had been given to:

______ The person subject of 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 plan.

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.

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.

Policy #1.30.30 **Page 6 of 6** **MHCTA-03**

Department of Health & Community Services
Mental Health Care and Treatment Act
Section 42

PLEASE PRINT LEGIBLY

COPY: ☐**Original** ☐**Patient** ☐**Patient Representative** ☐**Administrator** ☐**Rights Advisor**

☐ **Treatment Plan Member:** ____________________________

Community Treatment Plan

Person subject of the Community Treatment Order: ____________________________
(please print name of individual)

D.O.B.: ____________________ MCP #: ____________________________

Psychiatrist Issuing Order: ____
(please print name of psychiatrist)

Contact #: ____________________ E-Mail:____________________________

Person responsible for the general supervision and management of this plan (Section 42e):
Name (please print): ____
Contact #: ____________________ E-Mail:____________________________

Medical Supports:

Psychiatrist's Name (please print): ____________________________________
Contact #: ____________________ E-Mail:____________________________

Obligations: ____
____
____
____
____

Treatment/Medications: ____
____
____
____
____

Plan for Prescription Drug Coverage: ____________________________________

Policy #1.30.40 **Page 1 of 4** **MHCTA-04**

Psychiatrist's Name (please print): ______________________________

Contact #: ______________________________
E-Mail: ______________________________

Obligations: ______________________________
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____
____
____
____
____
____

Treatment/Medications: ______________________________
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____
____
____
____

Income:

Indicate this individual's source(s) of income: ______________________________
____
____

If in receipt of income support, please provide the name of his/her Income Support Worker (please print): ______________________________
Contact #: ______________ E-Mail: ______________

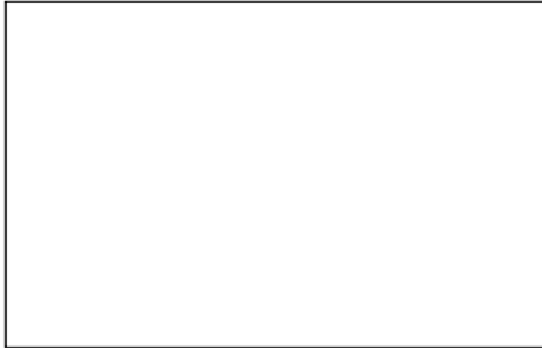
Housing:

Indicate the housing arrangement that is in place for this individual: ______________
____
____
____
____

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):
____
____
____
____

Primary Community Mental Health Service:



Name: ___________________________________
Position: _________________________________
Agency: __________________________________
____
Contact #:_________________________________
E-Mail: __________________________________
Obligations Re: Care/Support/Supervision:
____
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____
____

Secondary Services and Supports:

Name: ____________________________ Position: ________________________________
Agency: ____
Contact #:___________________________ E-Mail: _________________________________
Obligations Re: Care/Support/Supervision: ____
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Name: ____________________________ Position: ________________________________
Agency: ____
Contact #:___________________________ E-Mail: _________________________________
Obligations re: Care/Support/Supervision: ____
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Name: ____________________________ Position: ________________________________
Agency:____
Contact #:___________________________ E-Mail: _________________________________
Obligations Re: Care/Support/Supervision: ____
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Name: ________________________________
Position: ______________________________
Agency: ________________________________
Contact #: ______________________________
E-Mail: ________________________________
Obligations Re: Care/Support/Supervision:
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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: (as per Section 51)
____
____
____
____
____
____

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.

Department of Health & Community Services
Mental Health Care and Treatment Act
Section 50(4)

PLEASE PRINT LEGIBLY

COPY: ☐**Original** ☐**Patient** ☐**Patient Representative** ☐**Administrator** ☐**Rights Advisor**

☐ **Treatment Plan Member:** ___________________________

Notification Advising a Person That a Community Treatment Order is No Longer in Effect

NOTICE TO:

____
(please print name of individual who is the subject of the CTO)

A community treatment order issued on ____________________ pursuant to *The Mental Health Care and Treatment Act* with respect to: ________________________________
(date) ... *(please print name of patient)*

expired on ____________________, has not been renewed, and is no longer in force.
(date)

______________________________ ______________________________
Signature of Attending Physician ***Date***

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.

Policy #1.30.70 **Page 1 of 1** **MHCTA-07**

MENTAL HEALTH
Care & Treatment Act

Department of Health & Community Services
Mental Health Care and Treatment Act
Section 51(1)

PLEASE PRINT LEGIBLY

COPY: ☐Original (file) ☐Police ☐Administrator ☐Patient ☐Patient Representative

Order for the Apprehension, Conveyance and Examination of a Person who Failed to Comply to Community Treatment Order (CTO)

TO ANY PEACE OFFICER:

WHEREAS a community treatment order was issued on ________________________
(date of current CTO)

pursuant to Section _____ of *The Mental Health Care and Treatment Act* with respect to:

_____________________________________ AND WHEREAS the person has failed
(name of person who is the subject of the CTO)

to comply with the requirements of that community treatment order, and refuses to submit to a psychiatric examination;

AND WHEREAS reasonable efforts have been made to inform the person of his/her failure to comply with the CTO, of the possibility of the issuance of an apprehension order and the consequences of same, and having provided reasonable assistance to the person to comply with the terms of the CTO;

I, _____________________________________ being the psychiatrist responsible for the
(name of psychiatrist managing and supervising the CTO)

management and supervision of the CTO, hereby order that_____________________________
(name of person who is the subject of the CTO)

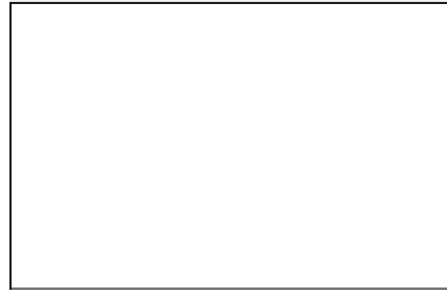
be apprehended and immediately conveyed to ______________________________ where,
(location)

within 72 hours after arrival at the facility, an involuntary psychiatric assessment shall be conducted on the person to determine whether:

- The CTO should be terminated and the person should be released without being to a community treatment order;
- The CTO should be continued, with any necessary variations; or
- The CTO should be revoked and a first certificate of involuntary admission completed in relation to the person.

This order gives authority to the Peace Officer to observe, detain and control the person during apprehension and conveyance (section 51(3)(b) of the Act).

This order gives authority to the Peace Officer to take reasonable measures, including the entering of premises and using physical restraint to apprehend the person and to take him or her into custody (section 51(3)(c) of the Act).



______________________________	______________________________
Signature of Psychiatrist Responsible for the Management and Supervision of the CTO	***Date***

NOTE:

The authority to apprehend and convey the person identified in this order shall expire 30 days after the date of the issuance of this order.

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.

Policy #1.30.80 **Page 2 of 2** **MHCTA-08**

MENTAL HEALTH
Care & Treatment Act

Department of Health & Community Services
Mental Health Care and Treatment Act

PLEASE PRINT LEGIBLY

COPY: ☐Original ☐Patient ☐Patient Representative ☐Administrator

Application / Withdrawal of Application for Review by the Mental Health Care and Treatment Review Board

Section 1. Application for Review

1. This application is being made on behalf of:

Name: ____
(print name of involuntary patient or person subject to CTO)

Address: ____

____

Phone: ________________________

2. Other contacts:

	Name	Address	Phone
Patient Representative:			
Social Worker:			
Psychiatrist:			
Rights Advisor:			

3. This Application is for: (Check one Box)

☐A review of the issuance of the certificate of involuntary admission

☐A review of the issuance of the certificate of renewal

☐A review of the issuance of the community treatment order

☐A review of the renewal of the community treatment order

☐An automatic review pursuant to Section 33 of the issuance of the certificate of renewal

☐An automatic review pursuant to Section 53(3) of the renewal of the community treatment order

☐A review of the denial of a right as set out in Section 11 or 12 of the *Mental Health Care and Treatment Act*

4. The date on the certificate or CTO is:
____

5. Please describe what you want the Review Board to do and why:_______________
____
____
____
____
____
____
____
____
____
____
____
____

______________________________________ ____________________________
Signature of Person Making Application ***Date***

Section 2. Withdrawal of Application for Review

______________________________________ ____________________________
Signature of Person Withdrawing Application ***Date***

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.

PLEASE INITIAL IN SPACES PROVIDED AND SIGN ATTACHED SIGNATURE KEY

Community Treatment Order (CTO) Checklist

Interpreter Required: ☐ Yes ☐ No

Community Treatment Order (Sections 40 & 41)

Completion of Assessment: Date: ____________ Time: ____________
(mm / dd / yy)

Date/time on CTO (within 72 hours of assessment): Date: ____________ Time: ____________
(mm / dd / yy)

Patient's status at time of CTO: ☐ Hospital ☐ Community

CTO copy provided to: Patient: ________ Patient Representative: ________ Rights Advisor: ________
Administrator (RHA): ________ Treatment Team Member (psychiatrist or designate): ________

Original CTO on health record: ☐ Yes ☐ No (If no, explain below)

____

Notification to Rights Advisor (1-888-546-1222) of the following:

Indicate date and time on the lines provided:

Issuance of CTO:____
Renewal of CTO:____
Amendment of CTO:____
Variation of CTO:____
Termination of CTO:____
Revocation of CTO:____

Rights Advisor has been notified of implementation of CTO : ☐ Yes
Date and time of notification to Telelink: ______________________________

Policy #1.30.150 **Page 1 of 8** **MHCTA-14**

Initial in spaces provided and sign the attached signature key.

Community Treatment Plan (Section 42)

Copy of Community Treatment Plan:

Original (must go in file): ________ Patient: _________ Patient Representative: _________
Rights Advisor: _________ Administrator: ________
Treatment Team Member (psychiatrist or designate): ________

Renewal of a Community Treatment Order (Sections 40, 41 & 43)

Person (and Patient Representative if applicable) has been:

______ Given a copy of the issued or renewed CTO by either the administrator or psychiatrist;

______ Advised of the right to retain and instruct counsel without delay in person or by other means;

______ Advised of the right to meet with a Rights Advisor; and

______ Advised of the right to apply to the Mental Health Care and Treatment Review Board for a review of the issuance or renewal of the CTO.

Person (and Patient Representative if applicable) has been advised about the functions and address of the Mental Health Care and Treatment Review Board, including responsibility for (Section 64):

______ Reviewing, upholding or overturning involuntary certifications and community treatment orders;

______ Conducting automatic reviews on all individuals on a community treatment order; and

______ Reviewing and making recommendations in situations of allegations of unreasonable denial of a Right.

Review Board Address:

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

All reasonable efforts have been made to determine whether the person has a patient representative: (Section 11(2))

If a person refuses to identify a patient representative, next of kin is offered: _________

Name of patient representative: ___________________________ Telephone: ____________________

Other relevant contact information: ____

Initial in spaces provided and sign the attached signature key.

Renewal of Community Treatment Order (cont'd) (Sections 43, 47, 48 & 53(3))

1st Renewal Date: ____________________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): ________ Patient: ________ Patient Representative: ________
Administrator: ________ Rights Advisor: _______ Community Treatment Team: ________

NOTE: MANDATORY REVIEW REQUIRED

2nd Renewal Date: ____________________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): _______ Patient: _______ Patient Representative: _______
Administrator: _______ Rights Advisor: _______ Community Treatment Team: ________

3rd Renewal Date: ____________________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): ________ Patient: ________ Patient Representative: _______
Administrator: ________ Rights Advisor: _______ Community Treatment Team: ________

NOTE: MANDATORY REVIEW REQUIRED

4th Renewal Date: ____________________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): _______ Patient: ________ Patient Representative: ________
Administrator: ________ Rights Advisor: ________ Community Treatment Team: ________

5th Renewal Date: ____________________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): _______ Patient: ________ Patient Representative: ________
Administrator: ________ Rights Advisor: _______ Community Treatment Team: _______

NOTE: MANDATORY REVIEW REQUIRED

Initial in spaces provided and sign the attached signature key.

6th Renewal Date: ____________________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): ________ Patient: ________ Patient Representative: ________
Administrator: ________ Rights Advisor: _______ Community Treatment Team: _______

Mandatory Review by the Mental Health Review Board (Section 53)

Completed Review Board application faxed to (709) 729-4429: ________

Copy provided to:

Original (must go in file): ________ Patient: ________ Patient Representative: ________
Administrator: ________ Rights Advisor: ________

Notification of Review Board hearing received: ________

Date/time of hearing: __________________________
(mm / dd / yy)

Copy of notification of hearing provided to:
Patient: _______ Patient Representative: ________ Administrator: ________ Rights Advisor: _______

Notification to Review Board Chair, by Fax (709) 729-4429, when:
CTO cancelled: ________ Application withdrawn: ________

Outcome of Hearing:
CTO confirmed: ________ CTO cancelled: ________

Amendment of a Community Treatment Order (Section 44)

Date: ______________________
(mm / dd / yy)

Where responsibility for the general supervision and management of a CTO is transferred to another psychiatrist and the order is amended, written notice of the transfer of supervision and management responsibilities shall be provided by the psychiatrist or administrator to:

_______ The Person who is the subject of the community treatment order;
_______ The Patient Representative;
_______ The Rights Advisor; and
_______ Each health care professional, person and organization named in the community treatment plan.

Initial in spaces provided and sign the attached signature key.

Expiry of a Community Treatment Order (Section 47)

Date: ____________________
(mm / dd / yy)

Where a CTO expires and is not renewed, written notice that the CTO is no longer in effect shall be provided by the psychiatrist or administrator to:

_______ The Person who is the subject of the community treatment order;
_______ The Patient Representative;
_______ The Rights Advisor; and
_______ Each health care professional, person and organization named in the community treatment plan.

Variation of a Community Treatment Plan (Section 49)

Date: ____________________
(mm / dd / yy)

Where a community treatment plan is varied by a psychiatrist, or by the community treatment team with the approval of the psychiatrist, the psychiatrist shall give a copy of the varied plan to:

_______ The Person who is the subject of the community treatment order;
_______ The Patient Representative;
_______ The Rights Advisor; and
_______ Each health care professional, person and organization named in the community treatment plan.

Termination of a Community Treatment Order (Section 50)

Date: ____________________
(mm / dd / yy)

The psychiatrist responsible for the management and supervision of the CTO may at any time and shall, at the request of the person who is the subject of the order, conduct a psychiatric assessment to determine if the person is able to continue to live in the community without being subject to the order.

Where, as a result of the assessment, the psychiatrist determines that the criteria for a CTO no longer continue to be met, the psychiatrist shall:

_______ Terminate the CTO; and

provide a written notice to:

_______ The person named in the CTO;
_______ The Patient Representative;

Policy #1.30.150 **Page 5 of 8** **MHCTA-14**

Initial in spaces provided and sign the attached signature key.

_______ The Administrator;

_______ The Rights Advisor; and

_______ The Community Treatment Team.

Revocation of a Community Treatment Order (Section 51)

Date: ______________________
(mm / dd / yy)

A psychiatrist who has reasonable grounds to believe that the person who is the subject of a CTO has Failed to comply with a condition of the CTO, he or she may issue an order in the approved form to a peace officer.

Prior to issuing an Apprehension Order, the psychiatrist shall:

_______ Have reasonable grounds to believe that the criteria required to issue a CTO continue to be met;

_______ Determine that the person refuses to submit to a psychiatric assessment; and

_______ Determine that reasonable efforts have been made to:

- _____ Inform the person of his or her failure to comply with the CTO;
- _____ Inform the person of the possibility that the psychiatrist may issue an order for an Involuntary psychiatric assessment and the possible consequences of that assessment; and
- _____ Provide reasonable assistance to the person to comply with the terms of the community treatment order.

Order for Apprehension, Conveyance and Examination of a Person who Failed to Comply to a CTO:

Copy: Original (must go in file): _______ Police: _______ Administrator: _______ Patient: _______
Patient Representative: _______

Date/time on Apprehension Order Date: ______________ Time: _______________
(mm / dd / yy)

Date/time of Expiry of Apprehension Order (within 30 days) Date: _________ Time: __________
(mm / dd / yy)

Policy #1.30.150 **Page 6 of 8** **MHCTA-14**

Initial in spaces provided and sign the attached signature key.

Upon a person being conveyed under the authority of an Apprehension Order, as soon as practicable, and in any event within 72 hours after arrival, a psychiatric assessment of the person shall be conducted to determine whether:

_____ The community treatment order should be terminated and the person should be released without being subject to a community treatment order (see Termination of a Community Treatment Order);

_____ The community treatment order should be continued, with any necessary variations (see Variation of a Community Treatment Order); or

_____ Where the person conducting the assessment is of the opinion that he or she meets the criteria for involuntary admission, the community treatment order should be revoked and a first certificate of involuntary admission completed.

Initial in spaces provided and sign the attached signature key.

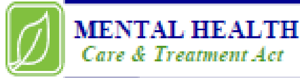
Signature Key			
Name	**Location**	**Phone Number**	**Initials**

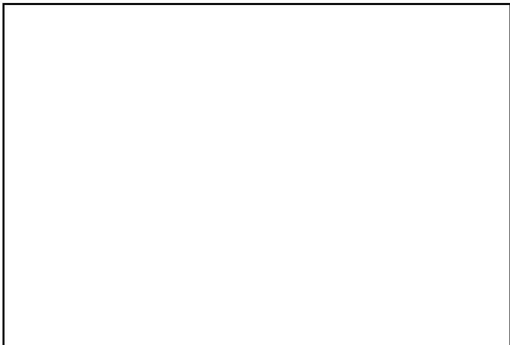
Policy #1.30.150 **Page 8 of 8** **MHCTA-14**

Initial in spaces provided and sign the attached signature key.

Appendix B: Mental Health Care and Treatment Act Associated CTO Forms

(June 2017)





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*):

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. ____ *(mm/dd/yy)*, 2. ____ *(mm/dd/yy)*, 3. ____ *(mm/dd/yy)*); or

(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 general supervision and management.

(please print name of psychiatrist)

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)*]: ____________

Treatment/Medications: ____________

Reporting Obligations [*Section 41(2)(e)*]: ____________

Plan for Prescription Drug Coverage: ____________

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

Care/Support/Supervision Obligations [*Section 42(f)*]: ____________

Treatment/Medications:

Reporting Obligations [*Section 41(2)(e)*]:

Income:
Indicate this individual's source(s) of income:

Housing:
Indicate the housing arrangement that is in place for this individual:

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):

Primary Community Mental Health Service:
Name: Position:
Agency:
Contact #: Email:

Care/Support/Supervision Obligations [*Section 42(f)*]:

Reporting Obligations [*Section 41(2)(f)*]:

Secondary Services and Supports:
Name: Position:
Agency:
Contact #: Email:

Care/Support/Supervision Obligations [*Section 42(f)*]:

Reporting Obligations [*Section 41(2)(f)*]:

Name: Position:
Agency:
Contact #: Email:

Care/Support/Supervision Obligations [*Section 42(f)*]:

Reporting Obligations [*Section 41(2)(f)*]:

Name: Position:
Agency:
Contact #: Email:

Care/Support/Supervision Obligations [*Section 42(f)*]:

Reporting Obligations [*Section 41(2)(f)*]:

Name: ______ Position: ______
Agency: ______
Contact #: ______ Email: ______

Care/Support/Supervision Obligations [*Section 42(f)*]: ______

Reporting Obligations [*Section 41(2)(f)*]: ______

Crisis Plan:

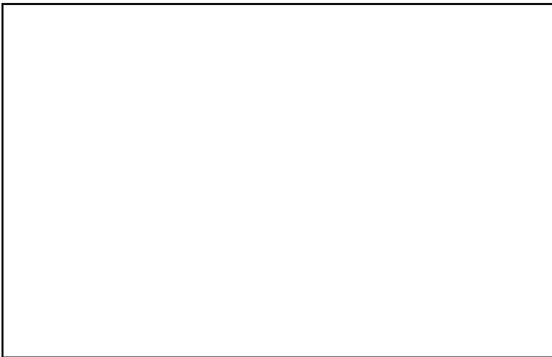
Obligation of person subject to the Community Treatment Order

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*)

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.



Department of Health & Community Services
Mental Health Care and Treatment Act
Section 50(4)

PLEASE PRINT LEGIBLY

COPY: ☐ Original ☐ Patient ☐ Patient Representative ☐ Administrator ☐ Rights Advisor

☐ Treatment Plan Member: ____________________

Notification Advising a Person That a Community Treatment Order is No Longer in Effect

NOTICE TO:

____
(please print name of individual who is the subject of the CTO)

A community treatment order issued on ______________ *(date)* pursuant to *The Mental Health Care and Treatment Act* with respect to: ______________________ *(please print name of patient)*

expired on ______________ *(date)*, has not been renewed, and is no longer in force.

______________________ ______________________
Signature of Attending Physician *Date*

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.

Policy #1.30.70 Page 1 of 1 MHCTA-07

Department of Health & Community Services
Mental Health Care and Treatment Act
Section 51(1)

PLEASE PRINT LEGIBLY

COPY: ☐**Original (file)** ☐**Police** ☐**Administrator** ☐**Patient** ☐**Patient Representative**

Order for the Apprehension, Conveyance and Examination of a Person who Failed to Comply to Community Treatment Order (CTO)

TO ANY PEACE OFFICER:

WHEREAS a community treatment order was issued on ____________________
(date of current CTO)

pursuant to Section _____ of *The Mental Health Care and Treatment Act* with respect to:

______________________________ AND WHEREAS the person has failed
(name of person who is the subject of the CTO)

to comply with the requirements of that community treatment order, and refuses to submit to a psychiatric examination;

AND WHEREAS reasonable efforts have been made to inform the person of his/her failure to comply with the CTO, of the possibility of the issuance of an apprehension order and the consequences of same, and having provided reasonable assistance to the person to comply with the terms of the CTO;

I, ______________________________ being the psychiatrist responsible for the
(name of psychiatrist managing and supervising the CTO)

management and supervision of the CTO, hereby order that ______________________________
(name of person who is the subject of the CTO)

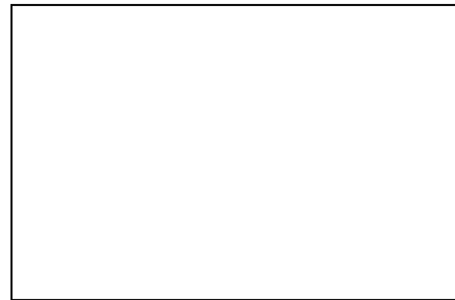
be apprehended and immediately conveyed to ______________________________ where,
(location)

within 72 hours after arrival at the facility, an involuntary psychiatric assessment shall be conducted on the person to determine whether:

- The CTO should be terminated and the person should be released without being to a community treatment order;
- The CTO should be continued, with any necessary variations; or
- The CTO should be revoked and a first certificate of involuntary admission completed in relation to the person.

This order gives authority to the Peace Officer to observe, detain and control the person during apprehension and conveyance (section 51(3)(b) of the Act).

This order gives authority to the Peace Officer to take reasonable measures, including the entering of premises and using physical restraint to apprehend the person and to take him or her into custody (section 51(3)(c) of the Act).

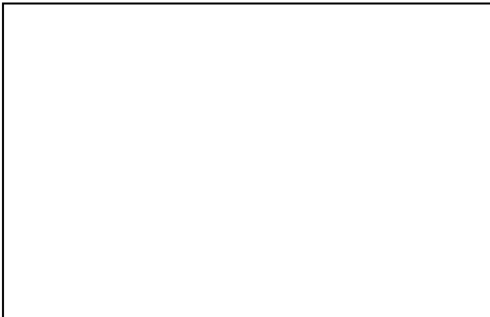


Signature of Psychiatrist Responsible for the Management and Supervision of the CTO	*Date*

NOTE:

The authority to apprehend and convey the person identified in this order shall expire 30 days after the date of the issuance of this order.

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.



PLEASE INITIAL IN SPACES PROVIDED AND SIGN ATTACHED SIGNATURE KEY

Community Treatment Order (CTO) Checklist

Interpreter Required: ☐ Yes ☐ No

Community Treatment Order (Sections 40 & 41)

Completion of Assessment: Date: ______________ Time: ______________
(mm / dd / yy)

Date/time on CTO (within 72 hours of assessment): Date: ______________ Time: ______________
(mm / dd / yy)

Patient's status at time of CTO: ☐ Hospital ☐ Community

CTO copy provided to: Patient: ________ Patient Representative: ________ Rights Advisor: ________
Administrator (RHA): ________ Treatment Team Member (psychiatrist or designate): ________

Original CTO on health record: ☐ Yes ☐ No (If no, explain below)

____

Notification to Rights Advisor (1-888-546-1222) of the following:

Indicate date and time on the lines provided:
Issuance of CTO: ______________________________
Renewal of CTO: ______________________________
Amendment of CTO: ______________________________
Variation of CTO: ______________________________
Termination of CTO: ______________________________
Revocation of CTO: ______________________________

Rights Advisor has been notified of implementation of CTO : ☐ Yes
Date and time of notification to Telelink: ______________________________

Policy #1.30.150	Page 1 of 8	MHCTA-14

Initial in spaces provided and sign the attached signature key.

Community Treatment Plan (Section 42)

Copy of Community Treatment Plan:

Original (must go in file): ______ Patient: ______ Patient Representative: ______
Rights Advisor: ______ Administrator: ______
Treatment Team Member (psychiatrist or designate): ______

Renewal of a Community Treatment Order (Sections 40, 41 & 43)

Person (and Patient Representative if applicable) has been:

______ Given a copy of the issued or renewed CTO by either the administrator or psychiatrist;

______ Advised of the right to retain and instruct counsel without delay in person or by other means;

______ Advised of the right to meet with a Rights Advisor; and

______ Advised of the right to apply to the Mental Health Care and Treatment Review Board for a review of the issuance or renewal of the CTO.

Person (and Patient Representative if applicable) has been advised about the functions and address of the Mental Health Care and Treatment Review Board, including responsibility for (Section 64):

______ Reviewing, upholding or overturning involuntary certifications and community treatment orders;

______ Conducting automatic reviews on all individuals on a community treatment order; and

______ Reviewing and making recommendations in situations of allegations of unreasonable denial of a Right.

Review Board Address:

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

All reasonable efforts have been made to determine whether the person has a patient representative: (Section 11(2))

If a person refuses to identify a patient representative, next of kin is offered: ______

Name of patient representative: ______ Telephone: ______

Other relevant contact information: ______

Policy #1.30.150 Page 2 of 8 MHCTA-14

Initial in spaces provided and sign the attached signature key.

Community Treatment Plan (Section 42)

Copy of Community Treatment Plan:

Original (must go in file): ______ Patient: ______ Patient Representative: ______
Rights Advisor: ______ Administrator: ______
Treatment Team Member (psychiatrist or designate): ______

Renewal of a Community Treatment Order (Sections 40, 41 & 43)

Person (and Patient Representative if applicable) has been:

______ Given a copy of the issued or renewed CTO by either the administrator or psychiatrist;

______ Advised of the right to retain and instruct counsel without delay in person or by other means;

______ Advised of the right to meet with a Rights Advisor; and

______ Advised of the right to apply to the Mental Health Care and Treatment Review Board for a review of the issuance or renewal of the CTO.

Person (and Patient Representative if applicable) has been advised about the functions and address of the Mental Health Care and Treatment Review Board, including responsibility for (Section 64):

______ Reviewing, upholding or overturning involuntary certifications and community treatment orders;

______ Conducting automatic reviews on all individuals on a community treatment order; and

______ Reviewing and making recommendations in situations of allegations of unreasonable denial of a Right.

Review Board Address:

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

All reasonable efforts have been made to determine whether the person has a patient representative: (Section 11(2))

If a person refuses to identify a patient representative, next of kin is offered: ______

Name of patient representative: ______ Telephone: ______

Other relevant contact information: ______

Initial in spaces provided and sign the attached signature key.

Renewal of Community Treatment Order (cont'd)
(Sections 43, 47, 48 & 53(3))

1st Renewal Date: ____________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): ______ Patient: ______ Patient Representative: ______
Administrator: ______ Rights Advisor: ______ Community Treatment Team: ______

NOTE: MANDATORY REVIEW REQUIRED

2nd Renewal Date: ____________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): ______ Patient: ______ Patient Representative: ______
Administrator: ______ Rights Advisor: ______ Community Treatment Team: ______

3rd Renewal Date: ____________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): ______ Patient: ______ Patient Representative: ______
Administrator: ______ Rights Advisor: ______ Community Treatment Team: ______

NOTE: MANDATORY REVIEW REQUIRED

4th Renewal Date: ____________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): ______ Patient: ______ Patient Representative: ______
Administrator: ______ Rights Advisor: ______ Community Treatment Team: ______

5th Renewal Date: ____________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): ______ Patient: ______ Patient Representative: ______
Administrator: ______ Rights Advisor: ______ Community Treatment Team: ______

NOTE: MANDATORY REVIEW REQUIRED

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Initial in spaces provided and sign the attached signature key.

6th Renewal Date: ____________
(mm / dd / yy)

Copy of Renewal:

Original (must go in file): ______ Patient: ______ Patient Representative: ______
Administrator: ______ Rights Advisor: ______ Community Treatment Team: ______

Mandatory Review by the Mental Health Review Board (Section 53)

Completed Review Board application faxed to (709) 729-4429: ______

Copy provided to:

Original (must go in file): ______ Patient: ______ Patient Representative: ______
Administrator: ______ Rights Advisor: ______

Notification of Review Board hearing received: ______

Date/time of hearing: ____________
(mm / dd / yy)

Copy of notification of hearing provided to:
Patient: ______ Patient Representative: ______ Administrator: ______ Rights Advisor: ______

Notification to Review Board Chair, by Fax (709) 729-4429, when:
CTO cancelled: ______ Application withdrawn: ______

Outcome of Hearing:
CTO confirmed: ______ CTO cancelled: ______

Amendment of a Community Treatment Order (Section 44)

Date: ____________
(mm / dd / yy)

Where responsibility for the general supervision and management of a CTO is transferred to another psychiatrist and the order is amended, written notice of the transfer of supervision and management responsibilities shall be provided by the psychiatrist or administrator to:

______ The Person who is the subject of the community treatment order;
______ The Patient Representative;
______ The Rights Advisor; and
______ Each health care professional, person and organization named in the community treatment plan.

Initial in spaces provided and sign the attached signature key.

Expiry of a Community Treatment Order (Section 47)

Date: ____________
(mm / dd / yy)

Where a CTO expires and is not renewed, written notice that the CTO is no longer in effect shall be provided by the psychiatrist or administrator to:

_______ The Person who is the subject of the community treatment order;
_______ The Patient Representative;
_______ The Rights Advisor; and
_______ Each health care professional, person and organization named in the community treatment plan.

Variation of a Community Treatment Plan (Section 49)

Date: ____________
(mm / dd / yy)

Where a community treatment plan is varied by a psychiatrist, or by the community treatment team with the approval of the psychiatrist, the psychiatrist shall give a copy of the varied plan to:

_______ The Person who is the subject of the community treatment order;
_______ The Patient Representative;
_______ The Rights Advisor; and
_______ Each health care professional, person and organization named in the community treatment plan.

Termination of a Community Treatment Order (Section 50)

Date: ____________
(mm / dd / yy)

The psychiatrist responsible for the management and supervision of the CTO may at any time and shall, at the request of the person who is the subject of the order, conduct a psychiatric assessment to determine if the person is able to continue to live in the community without being subject to the order.

Where, as a result of the assessment, the psychiatrist determines that the criteria for a CTO no longer continue to be met, the psychiatrist shall:

_______ Terminate the CTO; and

provide a written notice to:

_______ The person named in the CTO;
_______ The Patient Representative;

Initial in spaces provided and sign the attached signature key.

_______ The Administrator;

_______ The Rights Advisor; and

_______ The Community Treatment Team.

Revocation of a Community Treatment Order (Section 51)

Date: _______________
(mm / dd / yy)

A psychiatrist who has reasonable grounds to believe that the person who is the subject of a CTO has Failed to comply with a condition of the CTO, he or she may issue an order in the approved form to a peace officer.

Prior to issuing an Apprehension Order, the psychiatrist shall:

_______ Have reasonable grounds to believe that the criteria required to issue a CTO continue to be met;

_______ Determine that the person refuses to submit to a psychiatric assessment; and

_______ Determine that reasonable efforts have been made to:

- _____ Inform the person of his or her failure to comply with the CTO;
- _____ Inform the person of the possibility that the psychiatrist may issue an order for an Involuntary psychiatric assessment and the possible consequences of that assessment; and
- _____ Provide reasonable assistance to the person to comply with the terms of the community treatment order.

Order for Apprehension, Conveyance and Examination of a Person who Failed to Comply to a CTO:

Copy: Original (must go in file): _______ Police: _______ Administrator: _______ Patient: _______
Patient Representative: _______

Date/time on Apprehension Order Date: _______________ Time: _______________
(mm / dd / yy)

Date/time of Expiry of Apprehension Order (within 30 days) Date: __________ Time: __________
(mm / dd / yy)

Initial in spaces provided and sign the attached signature key.

Upon a person being conveyed under the authority of an Apprehension Order, as soon as practicable, and in any event within 72 hours after arrival, a psychiatric assessment of the person shall be conducted to determine whether:

_____ The community treatment order should be terminated and the person should be released without being subject to a community treatment order (see Termination of a Community Treatment Order);

_____ The community treatment order should be continued, with any necessary variations (see Variation of a Community Treatment Order); or

_____ Where the person conducting the assessment is of the opinion that he or she meets the criteria for involuntary admission, the community treatment order should be revoked and a first certificate of involuntary admission completed.

Initial in spaces provided and sign the attached signature key.

Signature Key

Name	Location	Phone Number	Initials

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Initial in spaces provided and sign the attached signature key.

Appendix C: Mental Health Care and Treatment Act

SNL2006 CHAPTER M-9.1

MENTAL HEALTH CARE AND TREATMENT ACT

Amended:

2008 c19; 2008 c47 s12; 2011 cC-37.00001 s50 (not in force - included here); 2012 c33 s3; 2013 c13 s7; 2013 c16 s25; 2014 c3

CHAPTER M-9.1

AN ACT RESPECTING MENTAL HEALTH CARE AND TREATMENT

(Assented to December 12, 2006)

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Be it enacted by the Lieutenant-Governor and House of Assembly in Legislative Session convened, as follows:

Short title

1. This Act may be cited as the *Mental Health Care and Treatment Act* .

2006 cM-9.1 s1

Interpretation

2. (1) In this Act

(a) "administrator" means the person in charge of administrative functions within a psychiatric unit and includes his or her designate;

(b) "attending physician" means the physician who is given responsibility for the observation, care and treatment of a person during the period that a certificate or order in respect of the person is in effect and includes an attending psychiatrist;

(c) "board" means the Mental Health Care and Treatment Review Board established under section 56;

(d) "certificate" means a certificate issued under this Act and includes a certificate of involuntary admission and a certificate of renewal;

(e) "community treatment order" means an order issued under subsection 40(2);

(f) "community treatment plan" means the plan referred to in paragraph 40(2)(c) that is a required part of a community treatment order;

(g) "court" means, unless the context indicates otherwise, the Provincial Court of Newfoundland and Labrador and includes a judge of the Provincial Court whether sitting in court or in chambers;

(h) "facility" means a place where a psychiatric assessment may be conducted and includes a physician's office;

(i) "involuntary patient" means a person who is the subject of 2 certificates of involuntary admission issued in accordance with section 17 or a certificate of renewal issued in accordance with paragraph 30(2)(a);

(j) "judge" means, unless the context indicates otherwise, a Provincial Court judge appointed under the *Provincial Court Act, 1991* and includes the chief judge;

(k) "mental disorder" means a disorder of thought, mood, perception, orientation or memory that impairs

(i) judgment or behaviour,

(ii) the capacity to recognize reality, or

(iii) the ability to meet the ordinary demands of life,

and in respect of which psychiatric treatment is advisable;

(l) "minister" means the minister appointed under the *Executive Council Act* to administer this Act;

(m) "next of kin" means the first named person or a member of the category of person on the following list who has reached the age of 19 years and is mentally competent and available:

(i) a spouse or cohabiting partner,

(ii) son or daughter,

(iii) father or mother,

(iv) brother or sister,

(v) grandson or granddaughter,

(vi) grandfather or grandmother,

(vii) uncle or aunt, and

(viii) nephew or niece;

(n) "nurse practitioner" means a nurse practitioner as defined in the *Registered Nurses Act* ;

(o) "peace officer" means

(i) a member of the Royal Canadian Mounted Police,

(ii) a member of the Royal Newfoundland Constabulary, and

(iii) a sheriff, sub-sheriff, bailiff and deputy sheriff appointed under the *Sheriff's Act, 1991* ;

(p) "physician" means a person who is licensed to engage in the practice of medicine in the province or is otherwise lawfully engaged in the practice of medicine in the province;

(q) "psychiatric unit" means a facility which is a hospital or part of a hospital and that has been designated by the minister for the observation, assessment, detention, custody, restraint, treatment, care and supervision of a person with a mental disorder;

(r) "psychiatrist" means a physician who holds a specialist's certificate in psychiatry issued by The Royal College of Physicians and Surgeons of Canada or equivalent qualification acceptable to the minister;

(s) "psychosurgery" means a procedure that by direct access to the brain removes, destroys or interrupts the normal connections of the brain for the primary purpose of treating a mental disorder but does not include neurosurgical procedures designed to treat reliably diagnosed organic brain conditions or epilepsy;

(t) "representative" means a person, other than a rights advisor, who has reached the age of 19 years and who is mentally competent and available who has been designated by, and who has agreed to act on behalf of, a person with a mental disorder and, where no person has been designated, the representative shall be considered to be the next of kin, unless the person with the mental disorder objects;

(u) "rights advisor" means a person appointed under section 13; and

(v) "voluntary patient" means a person who remains in a psychiatric unit with his or her consent or with the consent of a substitute decision-maker.

(2) A person who has a duty to inform or to advise under this Act satisfies that duty by informing or advising another to the best of his or her ability and in a manner that addresses the special needs of the person receiving the information or advice, whether or not that person understands the information or advice.

(3) For the purpose of this Act, except where otherwise indicated, a reference to "approved form" means a form approved by the minister.

2006 cM-9.1 s2

Purpose

3. (1) The purpose of the Act is as follows:

(a) to provide for the treatment, care and supervision of a person with a mental disorder that is likely to result in dangerous behaviour or in substantial mental or physical deterioration or serious physical impairment;

(b) to protect a person with a mental disorder from causing harm to himself or herself or another and to prevent a person with a mental disorder from suffering substantial mental or physical deterioration or serious physical impairment;

(c) to provide for the apprehension, detention, custody, restraint, observation, assessment, treatment and care and supervision of a person with a mental disorder by means that are the least restrictive and intrusive for the achievement of the purpose set out in paragraphs (a) and (b); and

(d) to provide for the rights of persons apprehended, detained, restrained, admitted, assessed, treated and cared for and supervised under this Act.

(2) Nothing in this Act shall be considered to affect the rights or privileges of a person except as specifically set out in this Act.

2006 cM-9.1 s3

PART I
GENERAL

Powers of minister

4. (1) The minister may, by order published in Part I of the *Gazette,* designate a facility or a part of a facility, a class or classes of facilities, a hospital or part of a hospital, or other place as a psychiatric unit for the assessment, treatment, care, supervision, custody or other purpose relating to persons having a mental disorder and upon publication of the order the facility, part of the facility, class or classes of facility, hospital or part of a hospital or other place described in the order shall operate and be used for the purpose specified in that order.

(2) The minister may approve forms for the purpose of this Act.

2006 cM-9.1 s4

Agreements

5. The minister may enter into agreements with the Government of Canada or another province or territory of Canada or with a person, entity or organization with respect to

(a) the provision and funding of mental health services;

(b) the transfer, reception, observation, assessment, detention, custody, restraint, treatment, care and supervision of persons with a mental disorder in a psychiatric unit;

(c) the assumption of all or part of the charges incurred by a resident of the province detained in or admitted to a hospital, mental health facility, psychiatric unit or treatment facility in another province or territory of Canada; and

(d) the sharing of costs, the provision of services, and treatment, care and supervision of persons with a mental disorder.

2006 cM-9.1 s5

Review of Act

6. The minister shall, every 5 years, conduct a review of this Act and the regulations and the principles upon which this Act is based and consider the areas in which improvements may be made and report his or her findings to the Lieutenant-Governor in Council.

2006 cM-9.1 s6

Protection from liability

7. (1) An action shall not be brought against, and an administrator, a physician, a psychiatrist, a rights advisor, a nurse practitioner, a health care professional, the board, a panel appointed by the chairperson of the board, a member of the board, or another person or organization shall not be liable for an act or failure to act, or for a proceeding initiated or carried out or purportedly initiated or carried out in good faith under this Act, or for carrying out duties or obligations under this Act or for an application, decision, order, certificate, notice or other authorization made or enforced or purported to be made or enforced in good faith under this Act.

(2) An action shall not be brought against, and a facility, a psychiatric unit, a hospital authority, a peace officer or the Crown or an officer, employee, servant or agent of a facility, a psychiatric unit, a hospital authority, a peace officer or the Crown shall not be liable for a tort committed by a person who is subject to a certificate or order issued under this Act while that certificate or order is in effect.

2006 cM-9.1 s7

Regulations

8. The Lieutenant-Governor in Council may make regulations

(a) prescribing the duties, functions and powers of rights advisors in addition to the duties, functions and powers prescribed by this Act;

(b) respecting appeals to the Trial Division from a decision of the board;

(c) prescribing the duties of the board and panels appointed under this Act and of the chairperson and members of the board, in addition to the requirements of this Act;

(d) respecting the assessment, admission, detention, custody, treatment, authorized leave, transfer, discharge and placement of persons having a mental disorder, including the specification of the contents of a certificate, order or other authorization or documentation in relation to the assessment, admission, detention, custody, treatment, leave, transfer or discharge of a person, in addition to the requirements of this Act;

(e) respecting the annual report of the board;

(f) respecting the proceedings of the board and of panels of the board, including the form and content of applications to the board, the conduct of hearings, the reception of evidence, the disposition of applications, the internal rules and procedures of the board and panels and the provision of notice and other communications to parties to an application and witnesses;

(g) respecting and governing community treatment orders and community treatment plans, including the contents of orders and their administration and enforcement;

(h) prescribing persons or classes of persons, in addition to physicians and nurse practitioners, who may complete and sign a certificate of involuntary admission;

(i) prescribing a place or classes of place at which a person may be detained pending conveyance to a psychiatric unit as provided for in section 25 and the powers and duties of persons in charge of that place or class of place with respect to the detained person;

(j) respecting the exercise of the rights set out in Part II of this Act;

(k) defining a word or expression used but not defined in this Act;

(l) re-defining or further defining a word or expression defined in this Act; and

(m) generally to give effect to the purpose of this Act.

2006 cM-9.1 s8; 2013 c13 s7

Offence

9. (1) A person who, for the purpose of obtaining a certificate, a renewal of a certificate, an order or other authorization under this Act, wilfully supplies an administrator, physician, nurse practitioner, psychiatrist or other person authorized by the regulations, a peace officer or another person having the custody, care, control or supervision of a person with a mental disorder, with untrue or incorrect information, is guilty of an offence.

(2) A person who commits an offence under subsection (1) is liable, on summary conviction, to a fine of not more than $2,000.

2006 cM-9.1 s9

PART II
RIGHTS AND RIGHTS ADVISORS

Duties of peace officer on apprehension or detention

10. Where a person is apprehended by a peace officer under the authority of subsection 18(2) or 19(4) or section 20, the peace officer shall promptly inform the person

(a) of the reasons for his or her apprehension or detention;

(b) that he or she is being taken to a facility for an involuntary psychiatric assessment; and

(c) that he or she has the right to retain and instruct counsel without delay.

2006 cM-9.1 s10

Duties of facility on apprehension or detention

11. (1) Where a person is conveyed to a facility for the purpose of an involuntary psychiatric assessment under the authority of subsection 18(2) or 19(4) or section 20, or is detained in a psychiatric unit under the authority of section 34 or 74 or subsection 81(4), upon arrival at the facility or at the time of detention, as the case may be, or if the person is apparently not able to understand, as soon as the person appears able to understand the information, the attending physician or his or her designate shall ensure that the person

(a) is informed

(i) where he or she is being detained,

(ii) the purpose of the detention, and

(iii) that he or she has the right to retain and instruct counsel without delay; and

(b) is provided with a copy of the certificate, order or other authorization under which he or she is apprehended or detained as soon as is reasonably practicable.

(2) The person in charge of a facility shall make best efforts to determine whether a person referred to in subsection (1) has a representative and, where a representative has been ascertained,

(a) ensure that the representative is informed as soon as is practicable following the person's arrival at or detention in the facility that

(i) the person is being detained in the facility for the purpose of an involuntary psychiatric assessment, and

(ii) the person detained has the right to retain and instruct counsel without delay; and

(b) provide the representative with a copy of the certificate, order or other authorization under which the person has been apprehended or detained.

(3) A person who is detained in a facility for the purpose of an involuntary psychiatric assessment under section 18, 19, 20, 34, 74 or subsection 81(4) shall not be denied

(a) access at any time to the person's legal counsel and the right to consult with legal counsel in private either in person or by other means;

(b) access to a telephone to make or receive calls;

(c) access to the person's representative and the right to meet in private with the representative either in person or by other means; and

(d) where applicable, access to visitors during scheduled visiting hours.

(4) The rights referred to in paragraphs (3)(b) to (d) may be subject to the reasonable limits that are prescribed in the regulations.

2006 cM-9.1 s11

Procedural rights of involuntary patient

12. (1) A person who is an involuntary patient shall not be denied

(a) the right to consult and instruct his or her legal counsel in private at any time either in person or by other means;

(b) access to a telephone to make or receive calls;

(c) access to visitors during scheduled visiting hours;

(d) access to the rights advisor;

(e) access to his or her representative; and

(f) access to materials and resources necessary to write and send correspondence, and reasonable access to correspondence that has been sent to the person.

(2) The rights referred to in paragraphs (1)(b) to (f) may be subject to the reasonable limits that are prescribed in the regulations.

(3) The administrator shall ensure that an involuntary patient is provided, at the time of admission, with an oral explanation of, and a written statement setting out, the rights referred to in subsection (1) and that a notice of those rights is prominently displayed in all wards and in public reception areas of the psychiatric unit.

(4) Where a person is admitted as an involuntary patient, or where the person's status as an involuntary patient is renewed, the attending physician shall ensure that he or she is

(a) informed of the reasons for the issuance of the certificates of involuntary admission or certificate of renewal;

(b) provided with a copy of the certificates of involuntary admission or certificate of renewal;

(c) advised of his or her right

(i) to retain and instruct counsel without delay, and

(ii) to meet with the rights advisor as provided for in paragraph 14(2)(a); and

(d) provided with a written statement setting out

(i) the functions of the board,

(ii) the address of the board, and

(iii) the right of the person or his or her representative acting on behalf of the person to apply to the board for a review of the certificates of involuntary admission or certificate of renewal.

(5) Where the person does not appear able to understand the information provided under subsection (4) at the time it is provided, the attending physician shall ensure that the information is repeated at the request of the person and again as soon as the person appears able to understand it.

(6) Where an involuntary patient does not understand or speak the language in which the information referred to in subsection (4) is provided, the attending physician shall advise the administrator and the administrator shall ensure that the involuntary patient is provided with the assistance of an interpreter.

(7) As soon as is practicable following the admission of a person as an involuntary patient or the renewal of a person's status as an involuntary patient, the administrator shall ensure that the involuntary patient's representative is informed

(a) of the person's status as an involuntary patient and the reasons for the issuance of the certificates of involuntary admission or the certificate of renewal;

(b) that the involuntary patient has the right to retain and instruct counsel without delay in private either in person or by other means;

(c) that the involuntary patient or his or her representative acting on his or her behalf may apply to the board for a review of the certificates of involuntary admission or the certificate of renewal; and

(d) that the representative has the right to meet with the rights advisor.

(8) The administrator shall provide a copy of all notices and other information required to be given to the involuntary patient to the representative.

2006 cM-9.1 s12

Rights advisor

13. (1) The minister may appoint one or more rights advisors in accordance with the regulations.

(2) A rights advisor shall not be a person who is

(a) involved in the direct clinical care of the person to whom the rights advice is to be given; or

(b) providing treatment or care and supervision under a community treatment plan.

2006 cM-9.1 s13

Functions of rights advisor

14. (1) The rights advisor may offer advice and assistance in accordance with this Act to

(a) a person who is an involuntary patient;

(b) a person who is residing in the community under a community treatment order or its renewal; and

(c) the representative of a person referred to in paragraph (a) or (b).

(2) The rights advisor shall

(a) meet in person or by other means as soon as possible with a person referred to in paragraph (1)(a) or (b) and in any event within 24 hours of the person becoming an involuntary patient or the issuance of a community treatment order and meet after that at the request of the person referred to in paragraph (1)(a) or (b) or as required by this Act or the regulations;

(a.1) contact a person referred to in paragraph (1)(a) or (b) and his or her representative within 10 days of the meeting referred to in paragraph (a) unless the person or the representative contacts the rights advisor first;

(b) explain the significance of a certificate of involuntary admission or a community treatment order or the renewal of a certificate of involuntary admission or a community treatment order to the person who is subject to the certificate or order;

(c) communicate information in a neutral, non-judgmental manner;

(d) meet as soon as is practicable in person or by other means with the representative of a person referred to in paragraph (1)(a) or (b) and after that at the request of the representative or as required by this Act or the regulations;

(e) at the request of the person or his or her representative, assist the person in making application to the board in accordance with this Act and the regulations;

(f) at the request of the person or his or her representative, assist the person in obtaining legal counsel;

(g) at the request of the person or his or her representative, accompany the person to board hearings;

(h) maintain confidentiality; and

(i) perform other functions prescribed by the regulations.

2006 cM-9.1 s14; 2014 c3 s1

Notice to rights advisor

15. (1) The administrator shall ensure that the rights advisor is given notice of

(a) a decision to admit or detain a person in a psychiatric unit;

(b) the filing of each certificate in respect of an involuntary patient;

(c) the cancellation or expiration of a certificate of involuntary admission and the release of an involuntary patient from a psychiatric unit;

(d) the change in status of a voluntary patient to an involuntary patient; and

(e) an application to the board under section 33.

(2) The administrator or attending psychiatrist, as appropriate, shall ensure that the rights advisor is given notice of

(a) the issuance, renewal, expiry, termination or revocation of a community treatment order; and

(b) an application to the board under subsection 53(3).

2006 cM-9.1 s15

PART III
ASSESSMENT, ADMISSION, TREATMENT AND DISCHARGE

Admission only on certificates

16. Except as otherwise provided in subsection 82(1), but notwithstanding another provision of this Act, a person may only be admitted to and detained in a psychiatric unit as an involuntary patient under the authority of 2 certificates of involuntary admission or a certificate of renewal completed in accordance with this Part.

2006 cM-9.1 s16

Certificate of involuntary admission

17. (1) A certificate of involuntary admission shall be in the approved form and shall contain the following information:

(a) a statement by a person described in subsection 17(2) that he or she has personally conducted a psychiatric assessment of the person who is named or described in the certificate within the immediately preceding 72 hours, making careful inquiry into all of the facts necessary for him or her to form an opinion as to the nature of the person's mental condition;

(b) a statement by the person who has conducted the psychiatric assessment referred to in paragraph (a) that, as a result of the psychiatric assessment, he or she is of the opinion that the person who is named or described in the certificate

(i) has a mental disorder, and

(ii) as a result of the mental disorder

(A) is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration or serious physical impairment if he or she is not admitted to and detained in a psychiatric unit as an involuntary patient,

(B) is unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding his or her need for treatment or care and supervision, and

(C) is in need of treatment or care and supervision that can be provided only in a psychiatric unit and is not suitable for admission as a voluntary patient;

(c) a description of the facts upon which the person who has conducted the psychiatric assessment has formed the opinion described in subparagraphs (b)(i) and (ii), distinguishing between the facts observed by him or her and those that have been communicated by another person;

(d) the time and date on which the psychiatric assessment was conducted;

(e) the dated signature of the person completing the certificate of involuntary admission; and

(f) another matter required by the regulations.

(2) A certificate of involuntary admission shall be completed and signed as follows:

(a) the first certificate of involuntary admission may be completed and signed by a physician, nurse practitioner or other person authorized by the regulations; and

(b) the second certificate of admission shall be completed by a psychiatrist or, where a psychiatrist is not readily available to assess the person and complete and sign a second certificate, by a physician who is a person other than the person who completed and signed the first certificate.

2006 cM-9.1 s17

Effect of one certificate of admission

18. (1) Where a person has been the subject of a psychiatric assessment by a person described in paragraph 17(2)(a) and the person conducting the psychiatric assessment is of the opinion that the criteria set out in subparagraphs 17(1)(b)(i) and (ii) are met, he or she shall complete and sign a first certificate of involuntary admission in accordance with subsection 17(1).

(2) The completion and signing of the first certificate of involuntary admission under subsection (1) is sufficient authority

(a) for a person acting under the authority of the certificate of involuntary admission

(i) to apprehend the person who is named or described in the certificate and to convey him or her without his or her consent to a facility for an involuntary psychiatric assessment by a person described in paragraph 17(2)(b), and

(ii) to observe, detain and control the person during his or her apprehension and conveyance to a facility;

(b) for the person who completed the first certificate of involuntary admission to authorize treatment for the person who is named or described in the certificate during apprehension and conveyance;

(c) for the person who is named or described in the certificate of involuntary admission to be detained, restrained, treated and assessed without his or her consent following his or her arrival at the facility for a period not to exceed 72 hours; and

(d) for a person described in paragraph 17(2)(b) to conduct an involuntary psychiatric assessment.

(3) The authority to apprehend and convey a person to a facility for a psychiatric assessment under subsection (2) shall expire 7 days after the date on which the first certificate of involuntary admission is completed and signed.

2006 cM-9.1 s18

Judge's order for involuntary psychiatric assessment

19. (1) Anyone who has reasonable grounds to believe that a person

(a) has a mental disorder;

(b) as a result of the mental disorder has caused or is likely to cause harm to himself or herself or others or is likely to suffer substantial physical or mental deterioration or serious physical impairment; and

(c) refuses to submit to a psychiatric assessment

may apply to a judge for an order for a psychiatric assessment of the person.

(2) An application under subsection (1) shall be in writing and under oath or affirmation and state reasons in support and may be made without notice to another person.

(3) A judge, after considering the allegations of the person making the application and the evidence of any witnesses, may issue an order for an involuntary psychiatric assessment of a person where the judge is satisfied that

(a) the allegations of the applicant are founded; and

(b) the person who is the subject of the application

(i) has a mental disorder,

(ii) requires a psychiatric assessment to determine whether he or she should be admitted to a psychiatric unit as an involuntary patient, and

(iii) has refused or is likely to refuse a psychiatric assessment.

(4) An order granted under this section

(a) shall direct a peace officer to apprehend and convey the person who is named or described in the order to a facility for an involuntary psychiatric assessment; and

(b) is sufficient authority

(i) for the peace officer to observe, detain and control the person named or described in the order during the apprehension and conveyance, and

(ii) for a person described in paragraph 17(2)(a) to conduct an involuntary psychiatric assessment.

(5) An order under subsection (3) shall expire 7 days after the date on which it is made.

(6) The procedures respecting an application for an order, the hearing of the application, the making of an order under this section and any forms shall be in accordance with rules made under the *Provincial Court Act, 1991* .

2006 cM-9.1 s19

Apprehension by a peace officer

20. Where a peace officer has reasonable grounds to believe that a person

(a) has a mental disorder;

(b) as a result of the mental disorder has caused or is likely to cause harm to himself or herself or another or is likely to suffer substantial physical or mental deterioration or serious physical impairment; and

(c) refuses to submit to a psychiatric assessment

and it is not feasible in the circumstances to make an application for an order under section 19, the peace officer may immediately apprehend that person and convey him or her to a facility for an involuntary psychiatric assessment.

2006 cM-9.1 s20

Powers and duties of person apprehending and conveying

21. (1) Where a person is apprehended and conveyed to a facility for an involuntary psychiatric assessment under section 18, 19, 20 or 51,

(a) the person effecting the apprehension and detention may take reasonable measures, including the entering of premises and the use of physical restraint, to apprehend the person and to take him or her into custody; and

(b) the person who is apprehended and detained shall be conveyed to a facility for a psychiatric assessment as soon as practicable and by the least intrusive means possible without compromising the safety of that person or the public.

(2) Where a person is apprehended and conveyed to a facility for an involuntary psychiatric assessment under section 18, 19 or 20, the person conducting the assessment shall be provided with

(a) the first certificate of involuntary admission, where the person is apprehended and conveyed under subsection 18(2);

(b) the judicial order made under subsection 19(3), where the person is apprehended and conveyed under subsection 19(4); or

(c) a written statement from a peace officer, where the person is apprehended and conveyed under section 20, setting out

(i) the name of the person conveyed, if known,

(ii) the date, time and place at which the person was apprehended, and

(iii) the grounds on which the peace officer formed his or her belief and any other information relating to the circumstances which led to the taking of the person into custody.

(3) A person who has effected an apprehension under section 18, 19, 20 or 51 shall remain at the facility and retain custody of the person who has been apprehended until the involuntary psychiatric assessment is completed.

(4) Subsection (3) does not apply where the person conducting the involuntary psychiatric assessment advises that continuing custody is not required.

2006 cM-9.1 s21; 2008 c19 s1

Assessment of detained person

22. (1) Where a person is conveyed to or detained in a facility under section 18, 19, 20 or 51, a psychiatric assessment shall be conducted as soon as practicable and in any event within 72 hours of the arrival of the person at the facility.

(2) A person who is detained at a facility for a psychiatric assessment under subsection (1) may be treated without his or her consent during the period of detention.

2006 cM-9.1 s22; 2008 c19 s2

No assessment or no admission

23. (1) Where a person has been conveyed to a facility under section 18, 19, 20 or 51 and

(a) a psychiatric assessment has not been conducted within 72 hours of arrival at the facility; or

(b) a psychiatric assessment has been conducted within 72 hours of arrival at the facility and it is the conclusion of the person conducting the assessment that the criteria set out in subparagraphs 17(1)(b)(i) and (ii) are not met,

the person in charge of the facility or other responsible person shall ensure that the person is promptly informed that he or she has the right to leave the facility, subject to a detention that is lawfully authorized otherwise than under this Act.

(2) Where a person is released from the facility under subsection (1), the person who brought the person to the facility or another person who has assumed custody shall, unless the detained person otherwise requests, arrange for the return of the person to the place where the person was when taken into custody or to another appropriate place.

2006 cM-9.1 s23; 2008 c19 s3

Admission on 2 certificates

24. Where 2 certificates of involuntary admission have been completed in accordance with section 17, the person named in the certificates shall be promptly admitted to a psychiatric unit as an involuntary patient and, where the second certificate has been completed at a facility other than a psychiatric unit, the person shall be immediately conveyed to a psychiatric unit for admission as an involuntary patient.

2006 cM-9.1 s24

Detention pending conveyance

25. Notwithstanding section 24, where 2 certificates of involuntary admission have been completed but it is not practicable to immediately convey the person who is the subject of the completed certificates to a psychiatric unit for admission as an involuntary patient, the person may be held at an appropriate place in accordance with the regulations for a period not exceeding 7 days, pending conveyance to the psychiatric unit.

2006 cM-9.1 s25

Admission to a treatment facility

26. (1) Notwithstanding section 24, where 2 certificates of involuntary admission have been completed but the attending physician is of the opinion that the person who is named in the certificates requires medical treatment or other health care services that cannot be supplied in a psychiatric unit, the person may be detained and treated at another place and shall be admitted to the psychiatric unit when the treatment is concluded, provided that the period of detention authorized by the certificates of involuntary admission has not expired.

(2) Where a person is detained in another place under subsection (1), the person in charge of the place where the person is detained has, in addition to the powers conferred upon him or her by the Act respecting that place, the powers and duties of an administrator under this Act in respect of the custody and control of the person and the person shall be considered to continue as an involuntary patient of the psychiatric unit in the same manner and to the same extent as if he or she were detained in the psychiatric unit.

2006 cM-9.1 s26

Certificates of involuntary admission to be filed

27. Where 2 certificates of involuntary admission have been completed and signed in accordance with section 17 and the person named in the certificates has been admitted as an involuntary patient, the original of each certificate of involuntary admission shall be placed in the patient's chart and a copy filed with the administrator of the psychiatric unit.

2006 cM-9.1 s27

Length of detention

28. Where a person has been admitted as an involuntary patient under section 24, he or she may be detained in the psychiatric unit for a period not to exceed 30 days from the date of the completion and signing of the first certificate of involuntary admission.

2006 cM-9.1 s28

Ongoing assessment

29. (1) During the period of detention referred to in section 28, the attending physician shall

(a) assess an involuntary patient on an ongoing basis; and

(b) conduct an assessment of the involuntary patient at the patient's request, except where an assessment has been conducted in the immediately preceding 48 hours,

in order to determine whether the criteria set out in subparagraphs 17(1)(b)(i) and (ii) continue to be met.

(2) Where, as a result of an assessment referred to in subsection (1), the attending physician is satisfied that the criteria referred to in subparagraphs 17(1)(b)(i) and (ii) do not continue to be met,

(a) the certificates of involuntary admission shall be cancelled and the patient's status as an involuntary patient shall be terminated; and

(b) the administrator shall advise the person of his or her change in status and of his or her right to leave the psychiatric unit, subject to a detention that is lawfully authorized other than under this Act.

2006 cM-9.1 s29

Renewal or discharge

30. (1) Where a person's status as an involuntary patient has not been terminated under subsection 29(2), within 72 hours immediately preceding the expiration of the 30 day period of detention referred to in section 28 the attending physician shall conduct a psychiatric assessment of the person in order to determine if the criteria set out in subparagraphs 17(1)(b)(i) and (ii) continue to be met.

(2) Where a psychiatric assessment of a person has been conducted under subsection (1) and the attending physician is satisfied

(a) that the criteria set out in subparagraphs 17(1)(b)(i) and (ii) continue to be met, he or she shall sign and complete a certificate of renewal; or

(b) that the criteria referred to in subparagraphs 17(1)(b)(i) and (ii) are not met, the person shall be advised that his or her status as an involuntary patient has been terminated and that he or she has the right to leave the psychiatric unit subject to any detention that is lawfully authorized otherwise than under this Act.

(3) The requirements of section 17 respecting a certificate of involuntary admission apply, with the necessary changes, to a certificate of renewal referred to in paragraph (2)(a), and, where a certificate of renewal has been completed and signed in accordance with this section, the original of the certificate of renewal shall be placed in the patient's chart and a copy filed with the administrator of the psychiatric unit.

2006 cM-9.1 s30

Detention under certificate of renewal

31. (1) Where a certificate of renewal has been completed and filed under subsection 30(2), an involuntary patient may be detained in a psychiatric unit according to the following:

(a) not more than 30 days under the first certificate of renewal;

(b) not more than 60 additional days under a second certificate of renewal; and

(c) not more than 90 additional days under a third or subsequent certificate of renewal.

(2) There are no limits upon the number of certificates of renewal which may be issued in respect of an involuntary patient.

(3) The requirements of sections 29 and 30 apply, with the necessary changes, to the assessment of an involuntary patient detained under a certificate of renewal.

2006 cM-9.1 s31

Discharge

32. Where an authorized period of detention has expired and a certificate of renewal has not been issued in respect of the involuntary patient, the administrator shall ensure that the person is promptly informed that his or her status as an involuntary patient is terminated and that he or she has the right to leave the psychiatric unit, subject to a detention that is lawfully authorized otherwise than under this Act.

2006 cM-9.1 s32

Automatic review of detention

33. (1) On the filing of a second certificate of renewal and on the filing of each second certificate of renewal after that, the administrator shall apply to the board for a review of the person's status as an involuntary patient.

(2) An application by an administrator under subsection (1) shall be considered to be an application by the patient and may be determined by the board as if it were an application made under paragraph 64(1)(a).

2006 cM-9.1 s33

Change in status of a voluntary patient

34. (1) A member of the nursing staff of a psychiatric unit may detain and where necessary restrain a voluntary patient requesting to be discharged if the staff person believes on reasonable grounds that the patient

(a) has a mental disorder;

(b) as a result of the mental disorder is likely to cause harm to himself or herself or another, or to suffer substantial mental or physical deterioration or serious physical impairment if he or she leaves the psychiatric unit; and

(c) requires a psychiatric assessment.

(2) Where a psychiatric assessment of the voluntary patient has been conducted and the person conducting the assessment is of the opinion that the criteria set out in subparagraphs 17(1)(b) (i) and (ii) are met, that person shall complete and sign a certificate of involuntary admission in accordance with

subsection 17(1) and sections 18, 22, 23 and 24 shall apply, with the necessary changes, to the person who is named in the certificate.

(3) The psychiatric assessment referred to in subsection (2) shall be completed as soon as practicable and in no case more than 4 hours following the request for discharge by the voluntary patient.

2006 cM-9.1 s34

Treatment

35. (1) Where a person is an involuntary patient, the attending physician or other person may, taking into account the best interests of the involuntary patient, perform or prescribe diagnostic procedures that he or she considers necessary to determine the existence or nature of a mental disorder, and administer or prescribe medication or other treatment relating to the mental disorder without the consent of the involuntary patient during the period of detention.

(2) For the purpose of subsection (1), in taking into account the best interests of the involuntary patient, the attending physician or other person shall consider

(a) whether the mental condition of the involuntary patient will be or is likely to be improved by the specified treatment;

(b) whether the mental condition of the patient will improve or is likely to improve without the specified treatment;

(c) whether the anticipated benefit from the specified treatment and other related medical treatment outweighs the risk of harm to the patient;

(d) whether the specified treatment is the least restrictive and least intrusive treatment that meets the requirements of paragraphs (a), (b) and (c); and

(e) the wishes of the involuntary patient expressed when the involuntary patient was competent.

(3) In the course of the application of diagnostic procedures or the administration of treatment, the attending physician and another health care professional involved in the treatment of the involuntary patient shall, where appropriate,

(a) consult with the involuntary patient and his or her representative;

(b) explain to the involuntary patient and his or her representative the purpose, nature and effect of the diagnostic procedure or treatment; and

(c) give consideration to the views of the involuntary patient and his or her representative with respect to the diagnostic procedure or treatment and alternatives and the manner in which diagnostic procedures or treatment may be provided.

2006 cM-9.1 s35

Prohibition on treatment

36. Psychosurgery shall not be performed on or administered to an involuntary patient.

2006 cM-9.1 s36

Authorized leave

37. (1) The attending physician or his or her designate may issue a pass, in the approved form, to an involuntary patient, permitting the patient to be absent from a ward or a psychiatric unit for a specified period of time, subject to the conditions specified in the pass and in the regulations.

(2) A copy of a pass issued under subsection (1) shall be in the approved form and filed with the administrator and the original shall be placed on the patient's chart.

(3) The provisions of this Act respecting an involuntary patient continue to apply, with the necessary changes, to an involuntary patient who has been issued a pass under subsection (1).

2006 cM-9.1 s37

Unauthorized leave

38. (1) Where an involuntary psychiatric patient is absent from a psychiatric unit and

(a) a pass has not been issued under subsection 37(1); or

(b) the period of leave authorized by the pass under subsection 37(1) has expired,

the administrator may issue an order, in writing, in the approved form and in accordance with the regulations, to a peace officer or other person designated by the administrator to apprehend the patient and return him or her to the psychiatric unit.

(2) An order under subsection (1) is sufficient authority for the peace officer or other person designated by the administrator to

(a) apprehend the person who is named or described in the order and to return him or her to the psychiatric unit; and

(b) observe, detain and control the person during his or her apprehension and return to a psychiatrist or a psychiatric unit.

(3) An order under subsection (1) expires 30 days after the day it is issued and where an involuntary patient has not been returned to the psychiatric unit within that time he or she shall be considered to have been discharged from the psychiatric unit.

(4) A person who is returned to a psychiatric unit under this section may

(a) be detained for the remainder of the authorized period of detention to which the person was subject when the person's absence was discovered; or

(b) where the authorized period of detention has expired during the period the person was absent from the psychiatric unit,

(i) be subject to a psychiatric assessment in order to determine whether a first certificate of involuntary admission should be completed in accordance with subsection 17(1); or

(ii) be discharged from the psychiatric unit, subject to a detention that may be authorized otherwise than under this Act.

(5) Where, as a result of a psychiatric assessment referred to in subparagraph (4)(b)(i), a certificate of involuntary admission is completed in accordance with subsection 17(1), sections 18, 22, 23 and 24 shall apply with respect to the admission of the person who is the subject of the certificate as an involuntary patient.

2006 cM-9.1 s38

Part does not apply

39. Nothing in this Part authorizes the granting of a pass under subsection 37(1) to an involuntary patient who is subject to a detention lawfully authorized under this Act.

2006 cM-9.1 s39

PART IV
COMMUNITY TREATMENT ORDERS

Community treatment order

40. (1) For purpose of this Part, "in the community" means outside a psychiatric unit.

(2) A psychiatrist may issue or renew a community treatment order with respect to a person where the following criteria are met:

(a) he or she has examined the person named in the order within the immediately preceding 72 hours and 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 the psychiatrist, he or she is of the opinion that

(i) the person is suffering from a mental disorder for which he or she is in need of continuing treatment or care and supervision in the community,

(ii) if the person does not receive continuing treatment or care and supervision while residing in the community, he or she is likely to cause harm to himself or herself or another, or to suffer substantial mental or physical deterioration or serious physical impairment,

(iii) as a result of the mental disorder, the person 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,

(iv) the services that the person requires 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,

(A) exist in the community,

(B) are available to the person, and

(C) will be provided to the person, and

(v) the person is capable of complying with the requirements for treatment or care and supervision set out in the community treatment order;

(b) during the immediately preceding 2 year period the person

(i) has been detained in a psychiatric unit as an involuntary patient on 3 or more separate occasions, or

(ii) has been the subject of a prior community treatment order;

(c) the person, the psychiatrist who is considering 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

(d) the psychiatrist who is considering 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.

2006 cM-9.1 s40

Form and contents of community treatment order

41. (1) A community treatment order shall be in the approved form and shall be signed by the attending psychiatrist who issues the order.

(2) A community treatment order shall

(a) set out the date on which the examination referred to in paragraph 40(2)(a) took place;

(b) set out the facts on which the psychiatrist has formed the opinion referred to in paragraph 40(2)(a);

(c) identify the psychiatrist who has issued the order and who is responsible for its general supervision and management;

(d) describe the community treatment plan referred to in paragraph 40(2)(c);

(e) identify the person who has agreed to accept responsibility for the general supervision and management of the community treatment plan and set out the reporting obligations of that person;

(f) identify the health professionals, persons and organizations referred to in paragraph 40(2)(d) who have agreed to provide treatment and support services and set out the reporting obligations of those persons; and

(g) [Rep. by 2014 c3 s2]

(h) satisfy another requirement prescribed by the regulations.

(3) In addition to the information required under subsection (1), a community treatment order shall also contain a notice in writing to the person who is the subject of the order advising him or her that

(a) he or she has the right to retain and instruct counsel without delay in person or by other means;

(b) he or she has the right to meet with a rights advisor as provided for in paragraph 14(2)(a); and

(c) he or she or his or her representative has the right to apply to the board for a review of the issuance, renewal or revocation of the community treatment order, including in this notice the functions and address of the board.

2006 cM-9.1 s41; 2014 c3 s2

Community treatment plan

42. A community treatment plan referred to in paragraph 40(2)(c) shall contain

(a) a plan of treatment for the person subject to the community treatment order that describes the necessary medical and other supports, including income and housing, required for the person to live in the community;

(b) conditions relating to the treatment or care and supervision of the person;

(c) the obligations of the person who is the subject of the community treatment order;

(d) the name of the psychiatrist who has issued the order and who is responsible for its general supervision and management;

(e) the name of the person who has agreed to accept responsibility for the general supervision and management of the community treatment plan;

(f) the names of the health care professionals, persons and organizations who have agreed to provide treatment or care and supervision under the community treatment plan and their obligations under the plan; and

(g) another requirement prescribed by the regulations.

2006 cM-9.1 s42

Notice of issue or renewal

43. Where a community treatment order is issued or renewed, a copy of the issued or renewed order shall be provided to the person who is the subject of the order, the person's representative, the rights advisor and each health care professional, person and organization named in the community treatment plan by

(a) 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

(b) by 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.

2006 cM-9.1 s43

Responsibility of attending psychiatrist

44. (1) Except as otherwise provided in subsection (2), the psychiatrist who issues a community treatment order is responsible for its general supervision and management.

(2) Where the psychiatrist who issues a community treatment order is unable to carry out his or her responsibilities under the order, he or she may designate another psychiatrist to act in his or her place with the consent of that psychiatrist, and the order shall be amended to reflect the transfer of responsibilities.

(3) Where, under subsection (2), responsibility for the general supervision and management of a community treatment order is transferred to another psychiatrist and the order is amended, written notice of the transfer of supervision and management responsibilities shall be provided to the person who is the subject of the community treatment order, that person's representative, the rights advisor and each health care professional, person and organization named in the community treatment plan by

(a) 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

(b) 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.

2006 cM-9.1 s44

Responsibilities of persons named in the order

45. (1) The psychiatrist who is responsible for the general supervision and management of a community treatment order may require reports on the condition of the person who is the subject of the order from the health care professionals, persons and organizations who are responsible for providing treatment or care and supervision under the community treatment plan.

(2) A health care professional, person or organization providing treatment or care and supervision to the person who is the subject of the order is responsible for implementing the community treatment plan to the extent described in the order.

2006 cM-9.1 s45

Treatment

46. Sections 35 and 36 apply, with the necessary changes, to the diagnostic procedures and treatment that a person is required to submit to under a community treatment order.

2006 cM-9.1 s46

Duration of order

47. (1) A community treatment order expires 6 months after the day it is made unless

(a) it is renewed in accordance with section 48; or

(b) before its expiry it is terminated under section 50 or revoked under section 51.

(2) Where a community treatment order expires and is not renewed, written notice that the order is no longer in effect shall be provided to the person who is the subject of the order, his or her representative, the rights advisor and each health care professional, person and organization named in the community treatment plan by

(a) 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

(b) by the psychiatrist responsible for the management and supervision of the community treatment order, where the person was not an involuntary patient at the time the order was issued.

2006 cM-9.1 s47

Renewal of community treatment order

48. (1) A community treatment order may be renewed at any time before its expiry for a period of 6 months.

(2) There are no limits on the number of renewals under subsection (1).

(3) The requirements of sections 40, 41 and 42 apply, with the necessary changes, to the renewal of a community treatment order.

2006 cM-9.1 s48

Variation

49. (1) A community treatment plan may be varied by

(a) the psychiatrist who is responsible for the general supervision and management of the community treatment order; or

(b) by a health care professional, person or organization named in the community treatment plan, with the approval of the psychiatrist who is responsible for the general supervision and management of the community treatment order.

(2) Where a community treatment plan has been varied under subsection (1), the psychiatrist who is responsible for the management and supervision of the community treatment order shall provide written notice of the variation to the person who is the subject of the order, his or her representative, the rights advisor and each health care professional, person and organization named in the community treatment plan who is affected by the variation.

2006 cM-9.1 s49

Termination

50. (1) While a community treatment order is in effect, the psychiatrist who is responsible for the management and supervision of the order may at any time and shall, at the request of the person who is the subject of the order, conduct a psychiatric assessment to determine if the person is able to continue to live in the community without being subject to the order.

(2) A psychiatrist may refuse to conduct the psychiatric assessment referred to in subsection (1) upon the request of the patient at any time during the 3 months following the date of the last psychiatric assessment.

(3) Where, as a result of the assessment conducted under subsection (1), the psychiatrist determines that the criteria referred to in subparagraphs 40(2)(a)(i), (ii) and (iii) no longer continue to be met, he or she shall

(a) terminate the community treatment order;

(b) provide written notice to the person who is the subject of the order that the order is no longer in effect and that he or she may live in the community without being subject to the order; and

(c) provide a copy of the notice referred to in paragraph (b) to the administrator, where appropriate, and to the person's representative, the rights advisor and each health care professional, person and organization named in the community treatment plan.

(4) A notice referred to in paragraph (3)(b) shall be in the approved form.

2006 cM-9.1 s50

Revocation of order

51. (1) Where the psychiatrist who is responsible for the management and supervision of a community treatment order has reasonable grounds to believe that the person who is the subject of the

order has failed to comply with a condition of the community treatment order, he or she may issue an order in the approved form to a peace officer.

(2) The psychiatrist shall not issue an order under subsection (1) unless

(a) he or she has reasonable grounds to believe that the criteria set out in subparagraphs 40(2)(a)(i), (ii) and (iii) continue to be met;

(b) the person who is the subject of the community treatment order refuses to submit to a psychiatric assessment; and

(c) reasonable efforts have been made to

(i) inform the person of his or her failure to comply with the community treatment order,

(ii) inform the person of the possibility that the psychiatrist may issue an order for an involuntary psychiatric assessment and the possible consequences of that assessment, and

(iii) provide reasonable assistance to the person to comply with the terms of the community treatment order.

(3) An order under subsection (1) is sufficient authority for a peace officer to

(a) apprehend the person who is named in the order and to convey him or her to a facility named in the order for involuntary psychiatric assessment;

(b) observe, detain and control the person during his or her apprehension and conveyance to the facility; and

(c) take reasonable measures, including the entering of premises and the use of physical restraint, to apprehend the person who is the subject of the order and to take him or her into custody.

(4) The authority to apprehend and convey the person under subsection (3) shall expire 30 days after the date of the issuance of the order.

(5) Where a person is conveyed to a facility under the authority of an order under subsection (1), as soon as practicable, and in any event within 72 hours after arrival, a psychiatric assessment of the person shall be conducted to determine whether

(a) the community treatment order should be terminated and the person should be released without being subject to a community treatment order;

(b) the community treatment order should be continued, with any necessary variations; or

(c) where the person conducting the assessment is of the opinion that the criteria set out in subparagraphs 17(1)(b)(i) and (ii) are met, the community treatment order should be revoked and a first certificate of involuntary admission completed in accordance with subsection 17(1).

(6) Sections 10 and 11 apply to a person who has been apprehended by a peace officer and conveyed to a facility for an involuntary psychiatric assessment under the authority of an order issued under subsection (1).

(7) Where a first certificate of involuntary admission is completed under paragraph (5)(c), sections 18, 22, 23 and 24 shall apply with respect to the admission of the person who is the subject of the certificate as an involuntary patient.

2006 cM-9.1 s51

Protection from liability

52. (1) Where the psychiatrist who is responsible for the management and supervision of a community treatment order believes on reasonable grounds and in good faith that a health care professional, other person or organization that is responsible for providing treatment or care and supervision under a community treatment plan is doing so in accordance with the plan, an action shall not be brought against the psychiatrist and he or she is not liable for a failure by that health care professional, other person or organization to provide treatment or care and supervision or for a default or neglect by that health care professional, person or organization in providing the treatment or care and supervision.

(2) Where a health care professional, other person or organization that is responsible for providing an aspect of treatment or care and supervision under a community treatment plan believes on reasonable grounds and in good faith that the psychiatrist who is responsible for the management and supervision of the community treatment order, or a psychiatrist designated under subsection 44(2) or another health care professional, person or organization named in the community treatment plan, is providing treatment or care and supervision in accordance with the plan, an action shall not be brought against, and the health care professional, person or organization person is not liable for, a failure by the psychiatrist or his or her designate or another health care professional, person or organization to provide treatment or care and supervision or for a default or neglect by that psychiatrist, designate, health care professional, person or organization in providing the treatment or care and supervision.

2006 cM-9.1 s52

Board review of order

53. (1) A person who is the subject of a community treatment order or his or her representative may apply to the board to review whether the criteria for issuing or renewing an assisted community treatment order are met.

(2) An application under subsection (1) may be made each time a community treatment order is issued or renewed.

(3) Where a community treatment order is renewed, and on the occasion of each second renewal after that, an application shall be made to the board for a review of the order by

(a) the administrator, where the person who is the subject of the community treatment order was an involuntary patient at the time the community treatment order was made; or

(b) the psychiatrist responsible for the management and supervision of the order, where the person who is the subject of the order was not an involuntary patient at the time the order was made,

except where application for review has been made by the person who is the subject of the order in the preceding month.

(4) An application under subsection (3) shall be considered to be an application by the patient and may be determined by the board as if it were an application made under paragraph 64(1)(b).

2006 cM-9.1 s53

No limitation

54. Nothing in this Part prevents a physician, nurse practitioner, other person authorized by the regulations, a peace officer or a judge from taking an action that he or she may take under Part III .

2006 cM-9.1 s54

PART V
MENTAL HEALTH CARE AND TREATMENT REVIEW BOARD

Parties defined

55. For the purpose of this Part, the following shall be considered to be parties to an application to the board under section 64:

(a) where an application is made to review the issuance of certificates of involuntary admission or a certificate of renewal, the involuntary patient and the administrator;

(b) where an application is made to review the issuance or renewal of a community treatment order, the person who is subject to the community treatment order and

(i) 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

(ii) the psychiatrist who is responsible for the management and supervision of the community treatment order, where the person who is the subject of the order was not an involuntary patient at the time the order was issued; and

(c) where an application is made alleging a violation of a right provided to a person under section 11 or 12, the person alleging the violation of the right and the person in charge of the facility.

2006 cM-9.1 s55

Mental Health Care and Treatment Review Board

56. (1) There shall be a Mental Health Care and Treatment Review Board to hear and decide applications under this Act.

(2) The board shall report annually to the minister on its operations and on another matter as required by the minister and perform the other functions that may be prescribed by the regulations.

2006 cM-9.1 s56

Appointment

57. (1) The board shall comprise a minimum of 13 members appointed by the Lieutenant-Governor in Council and include

(a) a chairperson, who is a member in good standing of the Law Society of Newfoundland and Labrador ;

(b) 4 persons, each of whom is a member in good standing of the Law Society of Newfoundland and Labrador and who expresses an interest in mental health issues;

(c) 4 persons, each of whom is a physician; and

(d) 4 persons, each of whom is neither a member of the Law Society of Newfoundland and Labrador nor a physician and each of whom expresses an interest in mental health issues, with preference being given to a person who is or has been a consumer of mental health services.

(2) A person appointed to the board shall have knowledge or experience that will assist the board to achieve its mandate and the composition of the board shall reflect the cultural, ethnic and regional diversity of the province.

2006 cM-9.1 s57; 2008 c19 s4

Term of appointment

58. (1) A member of the board shall be appointed for a term of 3 years.

(1.1) Where the term of a member expires, he or she continues to be a member until reappointed or replaced.

(2) Notwithstanding subsection (1), members of the first board appointed under this Act shall be appointed to the following terms:

(a) the chairperson and 2 persons referred to in each of paragraphs 57(1)(b), (c) and (d) shall be appointed for a term of 4 years; and

(b) 2 persons referred to in each of paragraphs 57(1)(b), (c) and (d) shall be appointed for a term of 3 years.

(3) A member of the board is eligible for reappointment for an additional single term of 3 years immediately upon the expiry of his or her initial term of office.

(4) Where a member has served 2 consecutive terms of office, that member shall not be eligible for reappointment to the board until one calendar year has elapsed from the date of expiry of his or her second term of office.

(5) Where a vacancy occurs on the board, the Lieutenant-Governor in Council shall appoint a replacement member from the same group as that of the member whose leaving created the vacancy, to serve out the unexpired portion of the term.

(6) The exercise of the powers of the board or of a panel shall not be impaired because of a vacancy in membership.

(7) All acts done by the board or by a member of the board shall, notwithstanding that it is afterwards discovered that there was a defect in the appointment or qualification of a person purporting to be a member of the board, be as valid as if that defect had not existed.

2006 cM-9.1 s58; 2012 c33 s3

Remuneration

59. The remuneration, benefits and expenses of the members of the board shall be determined by the Lieutenant-Governor in Council.

2006 cM-9.1 s59

Chairperson of board

60. (1) The chairperson of the board shall

(a) prepare the annual report of the board referred to in subsection 56(2);

(b) manage and plan the conduct of applications to the board and matters referred to it, including the assignment of members of the board to panels and the referral of applications to a panel; and

(c) exercise the powers and perform the functions that may be conferred on him or her under this Act or the regulations.

(2) The chairperson may delegate, in writing, his or her powers under this Act to a member of the board who is appointed under paragraph 57(1)(b), except the power to make an annual report.

(3) A delegation under subsection (2) may be made subject to those conditions and restrictions as the chairperson considers appropriate.

(4) Where the chairperson becomes permanently incapable of performing his or her responsibilities under this Act, the Lieutenant-Governor in Council shall appoint a new chairperson to serve out the unexpired portion of the chairperson's term.

2006 cM-9.1 s60

Panels

61. (1) A panel of 3 members of the board shall be appointed by the chairperson to hear and decide an application under section 64 as follows:

(a) 3 members of the board, one of each of whom shall be a person referred to in paragraphs 57(1)(b), (c) and (d); or

(b) the chairperson of the board and 2 other members, one of each of whom shall be a person referred to in paragraph 57(1)(c) and (d).

(2) A panel

(a) appointed under paragraph (1)(a) shall be chaired by a member of the board who is a person referred to in paragraph 57(1)(b); and

(b) appointed under paragraph (1)(b) shall be chaired by the chairperson of the board.

(3) Where, as result of absence, incapacity or for another reason, a member of the board appointed to a panel under subsection (1) is unable to continue his or her participation on the panel, the chairperson of the board may appoint as a replacement member of the board a person who is of the same class as that of the member whose leaving created the vacancy on the panel.

2006 cM-9.1 s61

Decision making procedure of panel

62. (1) A quorum for a panel of the board is the 3 members referred to in subsection 61(1).

(2) A decision of a panel shall be made by majority vote.

(3) Each member of a panel is entitled to one vote.

2006 cM-9.1 s62

Ineligibility to participate on panel

63. A member of the board shall not sit as a member of a panel where

(a) his or her participation in the panel would give rise to a reasonable apprehension of bias; or

(b) he or she has sat on a *Criminal Code* review board hearing in respect of a patient who is a party to an application under section 64.

2006 cM-9.1 s63

Jurisdiction of board

64. (1) In addition to the automatic reviews provided for in section 33 and subsection 53(3), the following applications may be made to the board:

(a) an application by an involuntary patient to review the issuance of certificates of involuntary admission or a certificate of renewal;

(b) an application by a person who is the subject of a community treatment order to review its issuance or renewal; and

(c) an application by a person detained in a facility alleging a denial of a right set out in section 11 or 12.

(2) An application by a person under subsection (1) may be made by the person's representative.

(3) Where an application is made under paragraph (1)(a) or (b) to review the issuance of certificates of involuntary admission or a certificate of renewal or the issuance or renewal of a community treatment order, and the certificate or order expires before a decision is made, the application shall be considered to have been withdrawn whether or not the certificate or order is renewed.

(4) An application to the board may be withdrawn at any time before a decision is made by serving a notice of withdrawal in the approved form on the chairperson of the panel and the other party to the application.

2006 cM-9.1 s64

Power to dismiss an application

65. (1) The chairperson of the board may summarily dismiss an application without referring it to a panel where

(a) the application, in the opinion of the chairperson, is vexatious, frivolous or is not made in good faith; or

(b) a review of the matter has been considered by the board in the preceding 30 days.

(2) A decision of the chairperson of the board under subsection (1) is not subject to appeal or review.

2006 cM-9.1 s65

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Application

66. (1) An application under section 64 shall be made to the board in accordance with the regulations.

(2) Except where an application is dismissed under subsection 65(1), within 2 clear days of receipt of an application the chairperson of the board shall appoint a panel and designate a chairperson of the panel and refer the application to the chairperson of the panel.

2006 cM-9.1 s66

Referral of application

67. (1) A panel shall hear and determine an application as soon as is reasonably possible and in any event no more than 10 clear days after receipt of the referral under subsection 66(2).

(2) Within 2 clear days of receipt of the referral of the application under subsection 66(2), the chair of the panel shall give notice of the date, time, place and purpose of the hearing to the parties to the application.

(3) The notice of application under subsection (2) shall

(a) include a copy of the application; and

(b) advise a party that he or she may make representations to the panel either in person or in writing and submit evidence relevant to the application by a date to be set out in the notice.

2006 cM-9.1 s67

Powers of panel

68. (1) A panel shall hear and consider applications in accordance with this Act and the regulations and for that purpose a member of the panel has all the powers, duties and immunities of a commissioner appointed under the *Public Inquiries Act,* and the panel shall be considered to be an investigating body for the purpose of the *Public Investigations Evidence Act* .

(2) It is the duty of a panel to inform itself fully of the facts by means of the hearing, and for this purpose, a panel may

(a) require the attendance of witnesses and the production of documents and records, in addition to the witnesses called and the documents and records produced by a party;

(b) arrange for the patient to be examined by a psychiatrist; and

(c) engage independent medical, psychiatric or other professional persons to present evidence and make submissions with regard to a matter before the board and invite submissions from any other person who, in the opinion of the panel, has a material interest in or knowledge of matters relevant to the application.

2006 cM-9.1 s68

Conduct of proceedings

69. (1) Every proceeding before a panel shall be conducted in private and in as informal a manner as is appropriate in the circumstances and as is consistent with the regulations.

(2) Notwithstanding subsection (1), the panel may permit a person who is not a party to be present during all or part of a hearing where the patient requests or consents to the attendance of that person and where the chairperson of the panel is of the opinion that there is no risk of harm or injustice to a person.

(3) In a proceeding before the panel

(a) all evidence shall be given under oath or affirmation, and for this purpose, an oath or affirmation may be administered by electronic or other means;

(b) a record shall be made of all evidence received or adduced in support of the application, and for this purpose, the record may be created in writing or by electronic recording; and

(c) the standard of proof is on the balance of probabilities and the onus of proof shall be on the administrator, the person in charge of the facility or the attending psychiatrist, as the case may be.

2006 cM-9.1 s69

Rights of parties

70. (1) A party to the proceedings has the right to

(a) be personally present during the presentation of evidence to the panel;

(b) be represented by counsel or another person;

(c) examine documentary evidence placed before the panel;

(d) present evidence; and

(e) cross-examine witnesses.

(2) Notwithstanding paragraph (1)(a), the person making an application may not be compelled to attend a hearing of the panel but the panel or a member of the panel may interview that person in private for the purpose of assisting it in reaching a decision.

(3) For the purpose of paragraph (1)(b), an involuntary patient or a person who is the subject of a community treatment order is considered to have the capacity to retain and instruct counsel for the purpose of a hearing before a panel and an appeal from the decision of a panel.

(4) Notwithstanding paragraphs (1)(a) and (c), where a panel is of the opinion that disclosure of the information to the person making the application would seriously endanger the health or safety of that person or another person, the panel shall disclose the information to the legal counsel or

representative of the person making the application but may refuse to disclose the information to the person making the application.

2006 cM-9.1 s70

Decision of the board

71. (1) Except in the case of a replacement member appointed under subsection 61(3), a member of a panel shall not participate in a decision unless he or she was present throughout the period the application was under review and heard the evidence of the parties.

(2) Within 3 clear days following the conclusion of its review, the chairperson of the panel shall deliver

(a) to each party, its decision, in writing, signed by the members of the panel, together with reasons in support of the decision, and where the decision of the panel is not unanimous, any dissenting opinion; and

(b) to the chairperson of the board, a copy of its decision, together with reasons, and any dissenting opinions, and a record of all evidence presented to the panel.

(3) The record of evidence referred to in paragraph (2)(b) shall be retained by the board for a period of 7 years and shall be available for examination upon the request of a party.

(4) In addition to the information referred to in paragraph (2)(a), the chairperson of the panel shall also advise each party of his or her right to appeal the decision of the panel in accordance with this Act and the regulations.

2006 cM-9.1 s71

Order of the panel

72. (1) In its decision, a panel may

(a) with respect to an application under paragraph 64(1)(a), confirm the person's status as an involuntary patient if it determines that the criteria for admission as an involuntary patient set out in subparagraphs 17(1)(b)(i) and (ii) were met at the time of the hearing of the application, notwithstanding a technical defect or error in a certificate of involuntary admission or certificate of renewal, or cancel the certificate, where it determines that the criteria for admission as an involuntary patient were not met at the time of the hearing of the application, and order the person to be released from the psychiatric unit, subject to a detention that is lawfully authorized otherwise than under this Act;

(b) with respect to an application under paragraph 64(1)(b), confirm the issuance or renewal of a community treatment order, where the panel determines that the criteria set out in subsection 40(2) were met at the time of the hearing of the application, notwithstanding a technical defect or formal error in the community treatment order, or cancel the order, where it determines that the criteria were not met at the time of the hearing of the application, and

allow the person to live in the community without being subject to the community treatment order; and

(c) with respect to an application under paragraph 64(1)(c), determine whether the person's rights were violated and recommend appropriate corrective action to the person in charge of the facility.

(2) A recommendation under paragraph (1)(c) is not binding on the person in charge of the facility and a failure or refusal by that person to comply with the recommendation may not be appealed or reviewed.

(3) A decision of the board confirming or cancelling a certificate or order applies to the certificate or order in force immediately before the making of the order by the board.

(4) Nothing in this section shall permit the discharge or release of a person who is subject to detention otherwise than under this Act.

(5) A decision of the panel shall be considered to be a decision of the board and may be appealed in accordance with section 73, except that the findings of the panel on questions of fact are final and are not subject to appeal.

2006 cM-9.1 s72; 2013 c13 s7

Appeal

73. (1) A party to an application may, within 30 days after receiving notice of a decision of the board, appeal the decision on a question of law to the Trial Division by filing a notice of appeal with the court.

(2) An appeal under this section shall be conducted in accordance with the regulations.

(3) An appeal under this section does not stay the decision being appealed unless the Trial Division orders otherwise.

2006 cM-9.1 s73; 2013 c16 s25

PART VI
CRIMINAL CODE AND TRANSFERS

Detention under ***Criminal Code***

74. (1) Where a person

(a) is found not criminally responsible on account of mental disorder or unfit to stand trial under Part XX.1 of the *Criminal Code* ; and

(b) is detained in a psychiatric unit by a disposition or order under the *Criminal Code,*

within 72 hours of arrival at the psychiatric unit the person shall be assessed without his or her consent by 2 persons, one of whom shall be a person described in paragraph 17(2)(a) and the other of whom shall

be a person described in paragraph 17(2)(b), and where each is of the opinion that the criteria set out in subparagraphs 17(1)(b)(i) and (ii) are met, each shall sign and complete a certificate of involuntary admission and the person shall be admitted to the psychiatric unit as an involuntary patient in accordance with section 24.

(2) A person referred to in subsection (1) who is admitted to a psychiatric unit as an involuntary patient under subsection (1) is subject to the provisions of this Act respecting involuntary patients, except as follows:

(a) there shall be no review under this Act of the order or disposition under the *Criminal Code* authorizing the detention;

(b) the provisions of this Act respecting the transfer of patients shall not apply where the terms of the committing order or disposition under the *Criminal Code* conflict with those provisions;

(c) the person may not be the subject of a community treatment order, including a renewal, while the detention under the *Criminal Code* is in effect; and

(d) the person may leave or be discharged from the psychiatric unit only in accordance with part XX.1 of the *Criminal Code* .

(3) Where a person has been detained under part XX.1 of the *Criminal Code* as unfit to stand trial or not criminally responsible on account of mental disorder or has been found not guilty by reason of insanity and the person's detention under the *Criminal Code* is about to expire, within 72 hours before the expiration of the detention the person shall be assessed without his or her consent by 2 persons, one of whom shall be a person described in paragraph 17(2)(a) and the other of whom shall be a person described in paragraph 17(2)(b), and where each is of the opinion that the criteria set out in subparagraphs 17(1)(b)(i) and (ii) are met, each shall sign and complete a certificate of involuntary admission and the person shall be admitted to the psychiatric unit as an involuntary patient in accordance with section 24 and the provisions of this Act respecting involuntary patients shall apply to that person.

2006 cM-9.1 s74

Transfer to another psychiatric unit

75. (1) Except as otherwise provided by the terms of an order or disposition under the *Criminal Code* , where an administrator believes that it is in the best interests of an involuntary patient to be treated in a psychiatric unit other than the psychiatric unit the patient is currently in, the administrator may authorize the transfer of the patient upon the agreement of the administrator of the other psychiatric unit.

(2) Where a patient is transferred to another psychiatric unit under subsection (1), the psychiatric unit receiving the patient has the same authority to detain or treat the patient as the psychiatric facility from which the patient was transferred had.

(3) An authorization to transfer shall be in the approved form.

2006 cM-9.1 s75

Temporary removal or transfer

76. (1) Where an involuntary patient requires hospital treatment or other services that cannot as appropriately be provided in a psychiatric unit, the attending physician, may, if otherwise permitted by law and with the consent of a physician in the other facility, transfer the patient to that treatment facility and return him or her to the psychiatric unit on the conclusion of the treatment, in accordance with the regulations.

(2) Where an involuntary patient is transferred under subsection (1),

(a) the administrator and the attending physician of the facility to which the patient is transferred have, in addition to the powers and duties conferred by another Act, the powers and duties under this Act in respect of the custody and control of the patient; and

(b) the patient shall be considered to continue as an involuntary patient of the psychiatric unit in the same manner and to the same extent and is subject to the same control as if he or she were in the psychiatric unit.

2006 cM-9.1 s76

Notice of transfer

77. Notice of a transfer under subsection 75(1) or 76(1) shall be given to the involuntary patient, his or her representative and the rights advisor.

2006 cM-9.1 s77

Adult offenders

78. (1) Where 2 certificates of involuntary admission have been signed and completed in accordance with section 17 respecting a person imprisoned or detained in a

(a) correctional institution as defined in the *Adult Corrections Act* ; or

(b) prison, jail or lockup operated by a police force,

the Minister of Justice or his or her deputy may order the removal of the person to a psychiatric unit.

(2) Where an order is made under subsection (1), the person in charge of the correctional institution, prison, jail or lockup, shall in accordance with the order, cause the person to be transported to the psychiatric unit named in the order and provide the administrator with the completed certificates of involuntary admission and a copy of the order.

(3) A person transported to a psychiatric unit under subsection (2) shall be detained in the psychiatric unit until the attending physician certifies that the criteria set out in subparagraphs 17(1)(b)(i) and (ii) do not continue to be met and the Minister of Justice or his or her deputy may then order the person to be

(a) returned to the correctional institution, prison, jail or lockup, as the case may be, where the person continues to be liable to imprisonment or detention; or

(b) discharged from custody.

(4) An order under subsection (1) or (3) shall be in the form approved by the Minister of Justice.

(5) Except for the purpose of returning the patient to his or her place of imprisonment, nothing in this section authorizes the discharge of a person who is imprisoned for an offence and whose sentence has not expired.

(6) A person transferred under the authority of subsection (1) shall be considered to be an involuntary patient admitted under section 24 of this Act and all the provisions respecting involuntary patients shall apply to that person except that legal custody over the person shall remain with the Minister of Justice.

2006 cM-9.1 s78

Young offenders

79. (1) Where 2 certificates of involuntary admission have been signed and completed in accordance with section 17 in respect of a young person who is detained in a youth custody facility, the provincial director may authorize the removal of the young person to a psychiatric unit.

(2) Upon the issuance of an authorization under subsection (1), the provincial director shall, in accordance with that authorization, cause the young person to be transported to the psychiatric unit named in the order and provide the administrator with the completed certificates of involuntary admission and a copy of the order.

(3) A young person transported to a psychiatric unit under subsection (2) shall be detained in the psychiatric unit until the attending physician certifies that the criteria set out in subparagraphs 17(1)(b)(i) and (ii) do not continue to be met and the provincial director may then order the person to be

(a) returned to a custody facility in accordance with the provisions of the *Youth Criminal Justice Act* (Canada), where the person continues to be liable to a period of custody or detention; or

(b) discharged from custody.

(4) An order under subsection (3) shall be in the approved form and in accordance with the regulations.

(5) Except for the purpose of returning the young person to his or her place of custody, nothing in this section authorizes the discharge of a person who is subject to detention or who has been sentenced to custody for an offence and whose custodial portion of the sentence has not expired.

(6) A young person transported to a psychiatric unit under the authority of subsection (1) shall be considered to be an involuntary patient admitted under section 24 of this Act and all the provisions respecting involuntary patients shall apply to that person except that legal custody over the person shall remain with the provincial director.

(7) For the purpose of this section, the terms "young person", "youth custody facility" and "provincial director" have the meaning ascribed to them in the *Youth Criminal Justice Act* (Canada).

2006 cM-9.1 s79

No appeal or review

80. Notwithstanding another provision of this Act, a decision to transfer a person under section 75, 76, 78 or 79 is not subject to appeal or to review.

2006 cM-9.1 s80

Transfer of patients to and from the province

81. (1) Where it appears to a physician

(a) that an involuntary patient in a psychiatric unit has come or been brought into the province and that the patient's care and treatment is the responsibility of another jurisdiction; and

(b) that it would be in the best interests of that patient to be cared for in another jurisdiction,

the attending physician may authorize the transfer of the patient to the other jurisdiction where the physician is satisfied that the patient will be the subject of a psychiatric assessment in the receiving jurisdiction.

(2) Notwithstanding another provision of this Act, no review or appeal lies from a decision to transfer a person under subsection (1).

(3) Where it appears to a physician

(a) that there is in another jurisdiction an involuntary patient in a psychiatric facility and the province is responsible for the patient's care and treatment; and

(b) that it would be in the best interests of the involuntary patient in the other jurisdiction to be removed to a psychiatric unit in the province,

the physician may, where satisfied that suitable arrangements have been made for the transport, care and custody of the involuntary patient, authorize in writing the transfer of the person into the province.

(4) Where a person has been transferred to the province under subsection (3), he or she may be detained and treated without his or her consent in a psychiatric unit for a period not to exceed 72 hours and shall be the subject of 2 psychiatric assessments in order to determine whether he or she should be admitted as an involuntary patient under section 24.

(5) An authorization referred to in subsections (1) and (2) shall be in the approved form.

2006 cM-9.1 s81; 2008 c47 s12

PART VII
TRANSITIONAL PROVISIONS, CONSEQUENTIAL AMENDMENTS AND REPEAL

Transitional

82. (1) Except as otherwise provided in this section, the repeal of the *Mental Health Act* and the coming into force of this Act shall not affect or invalidate an application, order, warrant, certificate or decision made under the authority of the *Mental Health Act* or other predecessor legislation.

(2) Where, on the day before the day on which this Act comes into force, a person is detained in a psychiatric unit as an involuntary patient under the *Mental Health Act* , a certificate of involuntary admission issued under that Act shall continue in force notwithstanding the repeal of that Act, but the provisions of this Act respecting involuntary patients shall apply to the person and, when the period of detention authorized under the *Mental Health Act* expires, the person shall be discharged unless he or she is admitted to the psychiatric unit as an involuntary patient in accordance with Part III of this Act.

(3) Where, immediately before the coming into force of this Act, a person

(a) has been found not criminally responsible on account of mental disorder or unfit to stand trial under Part XX.1 of the *Criminal Code* or not guilty by reason of insanity; and

(b) is detained in a psychiatric unit by a disposition or order under the *Criminal Code*

and, upon the coming into force of this Act, the person continues to be detained in a psychiatric unit by a disposition or order under the *Criminal Code* , within 30 days of the coming into force of this Act the person shall be assessed without his or her consent by 2 persons, one of whom shall be a person described in paragraph 17(2)(a) and the other of whom shall be a person described in paragraph 17(2)(b) and, where each is of the opinion that the criteria set out in subparagraphs 17(1)(b)(i) and (ii) are met, each shall sign and complete a certificate of involuntary admission in accordance with section 17 and the person shall be admitted to the psychiatric unit as an involuntary patient under section 24.

(4) Notwithstanding the repeal of the *Mental Health Act* and the abolition of the Mental Health Review Board established under that Act, that board is continued for the purpose of hearing and determining an application which was made to it before the coming into force of this Act.

(5) An application referred to in subsection (4) shall be determined within 30 days after the day this Act comes into force and a person aggrieved by the decision of that board may, within 30 days of the decision, appeal from or against that decision as if the *Mental Health Act* had not been repealed.

(6) Where a person's status as an involuntary patient under the *Mental Health Act* continues in force under subsection (1), the person may apply to the board established under this Act for a review of his or her status under paragraph 64(1)(a) except where an application in relation to this matter has been continued under subsection (4).

2006 cM-9.1 s82

Consequential amendments

83. (1) Subparagraph 2(g)(iv) of the *Access to Information and Protection of Privacy Act* is amended by striking out the words "the Mental Health Review Board" and substituting the words "the Mental Health Care and Treatment Review Board".

(2) Paragraph 2(b) of the *Advance Health Care Directives Act* is repealed and the following substituted:

(b) "health care decision" means a consent, refusal to consent, or withdrawal of consent of any care, treatment, service, medication, or procedure to maintain, diagnose, treat, or provide for an individual's physical or mental health or personal care and includes

(i) life-prolonging treatment,

(ii) psychiatric treatment for a person other than a person admitted to a psychiatric unit as an involuntary patient under section 24 or detained in a psychiatric unit under subsection 81(4) or released into the community under a community treatment order under subsection 40(2) of the *Mental Health Care and Treatment Act* ,

(iii) the administration of nutrition and hydration, and

(iv) admission to treatment facilities and removal from those institutions, other than the admission, transfer, removal or discharge of a person admitted as an involuntary patient under section 24 or detained in a psychiatric unit under subsection 81(3) or released into the community under an assisted community treatment order under subsection 40(2) of the *Mental Health Care and Treatment Act* ;

(3) The Schedule to the *Child and Youth Advocate Act* is amended by striking out the words "Mental Health Review Board" and substituting the words "Mental Health Care and Treatment Review Board".

(4) The Schedule to the *Citizens' Representative Act* is amended

(a) by adding immediately after the words "Insurance Adjusters, Agents and Brokers Appeal Board" the words "Mental Health Care and Treatment Review Board"; and

(b) by striking out the words "Mental Health Review Board".

(5) Paragraph 7(b) of the *Fatalities Investigations Act* is amended by striking out the words "*Mental Health Act* " and substituting the words "*Mental Health Care and Treatment Act*".

(6) Paragraphs 2(c) and (f) of the *Mentally Disabled Persons' Estates Act* are amended by striking out the words "*Mental Health Act* " where they twice occur and substituting the words "*Mental Health Care and Treatment Act* ".

(7) Subsection 20(1) of the *Mentally Disabled Persons' Estates Act* is amended by striking out the words "who has been committed to the hospital under and in accordance with the *Mental Health*

***Act* " and substituting the words "who has been admitted to the hospital as an involuntary patient under the *Mental Health Care and Treatment Act* ".**

(8) Subsection 20(6) of the *Mentally Disabled Persons' Estates Act* is repealed and the following substituted:

(6) Where, while a patient of the hospital, a person who is voluntarily a patient of the hospital is admitted as an involuntary patient under the *Mental Health Care and Treatment Act* , the date of admission for purpose of this section is the date on which the first certificate of involuntary admission was completed and signed.

(9) Subparagraph 2(i)(ii) of the *Neglected Adults Welfare Act* is amended by striking out the words "*Mental Health Act* " and substituting the words "*Mental Health Care and Treatment Act* ".

2006 cM-9.1 s83

RSNL1990 cM-9 Rep.

84. The *Mental Health Act* is repealed.

2006 cM-9.1 s84

Commencement

85. This Act shall come into force on October 1, 2007 , except for Part IV which shall come into force on January 1, 2008 .

2006 cM-9.1 s85

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Appendix D: Mental Health Care and Treatment Act Provincial Policy and Procedure Manual

Newfoundland Labrador

Government of Newfoundland and Labrador
Department of Health and Community Services

Mental Health Care and Treatment Act

Provincial Policy and Procedure Manual

Updated: October 2015

A copy of the Act is contained in the manual and labelled as Appendix A. Page numbers in the Act are Policy and Procedure Manual page numbers, not the page numbers of the Act.

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Introduction

The *Mental Health Care and Treatment Act* (Appendix A, "the Act") is the legislative authority for the delivery of mental health services to persons who are involuntary certified. It provides the criteria and procedures for deciding if a person should be involuntarily certified.

The purpose of the Act is stated in Section 3. The Act was designed:

(a) to provide for the treatment, care and supervision of a person with a mental disorder that is likely to result in dangerous behaviour or in substantial mental or physical deterioration or serious physical impairment;

(b) to protect a person with a mental disorder from causing harm to himself or herself or another and to prevent a person with a mental disorder from suffering substantial mental or physical deterioration or serious physical impairment;

(c) to provide for the apprehension, detention, custody, restraint, observation, assessment, treatment and care and supervision of a person with a mental disorder by means that are the least restrictive and intrusive for the achievement of the purpose set out in paragraphs (a) and (b); and,

(d) to provide for the rights of persons apprehended, detained, restrained, admitted, assessed, treated and cared for and supervised under this Act.

The majority of people who need treatment for mental illness receive it on a voluntary basis. The Act only applies to the small number of individuals who require detention and treatment on an involuntary basis. The policy directions reflected in the Act were generated by a multi-sectoral stakeholder committee that has been meeting since 2000, and have received strong support in a series of targeted public consultations.

Purpose

This manual was designed to assist the regional health authorities in implementing and interpreting the Act. The manual must be read in conjunction with the Act. The manual establishes the policies to follow to ensure consistent and quality implementation of the Act across the province. These policies were developed by the Department of Health and Community Services, with input from the regional health authorities, consumer and stakeholder groups.

Every effort has been made to ensure accuracy, in the event of an error in the manual, please call (709) 729-3658.

Structure and Numbering

The policies are grouped in sections as indicated in the Table of Contents. Each section of the manual has an Arabic number and each policy within the section has an Arabic number which is a subset of the section number (e.g. 2.10). Multiples of 10 have been used to identify sequential policies within the same section. Reserve numbers are available for the addition of new policies.

Responsibility for Manual Review, Revisions and Additions

The Department of Health and Community Services will review the manual at least once every three years. Specific issues may be reviewed as they arise. Upon review and consultation, any changes and additions will be forwarded to the regional health authorities for inclusion in the manual. An up-to-date version of the manual will be available on the Department of Health and Community Services' website.

Upon receiving a request for a revision or addition, the regional health authorities will:

- Review the request for revisions or additions;
- Determine if the suggestion is requirement related;
- Endeavour to clarify; and,
- Forward requested edits and/or suggestions to the Department of Health and Community Services.

The Department of Health and Community Services will:

- Research proposed material as necessary;
- Review, revise or edit material for appropriateness to the manual;
- Incorporate new or revised policy(s) in the manual;
- Distribute copies of the new or revised policy(s) and revised Table of Contents to the regional health authorities, if applicable; and,
- Update the manual on the Department of Health and Community Services' website.

Responsibility for the Evaluation of the Act

In conjunction with the regional health authorities and community mental health agencies, the Department of Health and Community Services will also, on a yearly basis monitor the effectiveness of the Act as per evaluation criteria with a view to preparing for the ministerial review that must be conducted every five years.

Definitions

- "Administrator" means the person in charge of administrative functions within a psychiatric unit and includes his or her designate(s).
- "Attending physician" means the physician who is given responsibility for the observation, care and treatment of a person during the period that a certificate or

community treatment order in respect of the person is in effect and includes an attending psychiatrist.

- "Board" means the Mental Health Care and Treatment Review Board.
- "Facility" means a place where a psychiatric assessment may be conducted and includes a physician's office.
- "Involuntary patient" means a person who is the subject of 2 certificates of involuntary admission issued in accordance with section 17 or a certificate of renewal issued in accordance with paragraph 30(2)(a).
- "Peace officer" means a member of the Royal Canadian Mounted Police, a member of the Royal Newfoundland Constabulary, and a sheriff, sub-sheriff, bailiff and deputy sheriff appointed under the *Sheriff's Act, 1991*.
- "Physician" means a person who is licensed to engage in the practice of medicine in the province or is otherwise lawfully engaged in the practice of medicine in the province.
- "Psychiatric unit" means a facility which is a hospital or part of a hospital and that has been designated by the minister for the observation, assessment, detention, custody, restraint, treatment, care and supervision of a person with a mental disorder. The minister has designated six facilities as psychiatric units:
  - Western Memorial Regional Hospital – Corner Brook
  - Central Newfoundland Regional Health Centre – Grand Falls-Windsor
  - Waterford Hospital – St. John's
  - Health Sciences Centre – St. John's
  - St. Clare's Mercy Hospital – St. John's
  - Janeway Children's Hospital – St. John's
- "Patient representative" means a person, other than the rights advisor, who has reached the age of 19 years and who is mentally competent and available who has been designated by, and who has agreed to act on behalf of a person with a mental disorder. Where no other person has been designated, the representative shall be considered to be the next of kin, unless the person with the mental disorder objects.
- "Safe space" means a specially designed room (see specification in Appendix E) in or near the emergency department of a health facility that is used for assessing a patient for involuntary admission. If the patient is deemed certifiable and requires a transfer to a psychiatric unit, the patient may be detained in this area. In facilities where there is no psychiatric unit, the safe space should be built so that it may also function as a seclusion room.
- "Seclusion room" means a specially designed locked room on a psychiatric unit which is used to provide privacy, safety and seclusion for an agitated person. Controlling the person's environment by removing people, ward activity and other stimuli provides an opportunity for the person to calm themselves and regain composure. It is used often in combination with medication and serves to de-escalate a situation which may be dangerous to the agitated person or those around him or her.
- "Staff" means the appropriate administrative and clinical personnel and physicians of a regional health authority.

DEPARTMENT OF HEALTH AND COMMUNITY SERVICES
Mental Health Care and Treatment Act – Provincial Policy Manual

Section 1.0 Regional Health Authority	Policy : 1.10 – 1.90
Effective Date: October 1, 2007	Revised: October 2015

1.0 Regional Health Authority

1.10 Education Requirements

The regional health authority shall ensure:

- Staff are educated and aware of the rights of the patient as outlined in the Act (see Appendix B);
- Staff are educated and aware of the role and responsibilities of the rights advisor (see section 4.0);
- Staff are educated and aware of the role of the representative (See section 3.0);
- Staff are educated and aware of the role and responsibilities of the health professionals, persons and organizations named in a community treatment plan (See section 5.0);
- Staff are aware of the certification process as outlined in the Act (See Appendix C);
- Attending physicians, administrators and the psychiatrists who issue community treatment orders are aware of their duties as outlined in the Act (see Appendix D);
- Nursing and administrative staff are aware of the time lines in the Act and how they are to be tracked in accordance with provincial policy; and,
- Copies of the Act are available on all psychiatric units and in all emergency departments.

1.20 Facility Requirements

The regional health authority shall ensure:

- There is a safe space available in the emergency department of the health facility in which the psychiatric assessment is conducted. This policy applies to all facilities that have psychiatric units and other facilities designated as safe spaces in the region. In facilities that have psychiatric inpatient beds, this space will be a safe space only. In facilities that have no psychiatric inpatient beds, this space shall double as a safe space/seclusion room (See Appendix E for specifications for a safe space);
- There is a seclusion room in all facilities that have psychiatric units;
- Involuntary patients have access to materials and resources necessary to write and send correspondence, and reasonable access to correspondence that has been sent to them;
- Involuntary patients have access to a telephone;
- There is space available for a person awaiting a psychiatric assessment and an involuntary patient to consult with a lawyer in private;

- Video conferencing is available for use, as appropriate;
- The Patients' Rights poster is prominently displayed in all inpatient areas and public reception areas of the psychiatric unit;
- There is a designated space in the facility where copies of the certificates of involuntary admission and certificates of renewal are filed;
- Patients and persons awaiting psychiatric assessment have access to visitors during visiting hours; and,
- Involuntary patients have access to an interpreter if required.

1.30 Forms

The regional health authorities shall ensure that staff is able to access all the approved current forms and that the forms are completed as required under the Act.

1.30.10 Certificates of Involuntary Admission

- In accordance with *Section 17(1)* of the Act, a certificate of involuntary admission shall be in the approved form (See form **MHCTA–01**, Appendix I).
- A copy of the certificate of involuntary admission must be provided to the administrator, the person and the patient representative.

1.30.20 Certificate of Renewal

- In accordance with *Section 30(2)* of the Act, a certificate of renewal shall be signed in the event an involuntary patient continues to meet the criteria of an involuntary patient and the detention period is about to expire (See form **MHCTA-02,** Appendix I).
- A copy of the certificate of renewal shall be provided to the administrator, the person and the patient representative.

1.30.30 Community Treatment Order

- In accordance with *Section 41(1)* of the Act the community treatment order shall be completed in the approved form (See form **MHCTA-03**, Appendix I).
- The form shall be signed by the attending psychiatrist who issued the order.
- A copy of the issued or renewed community treatment order shall be provided to the person who is the subject of the order, the patient representative, the rights advisor and each health care professional, person, and organization named in the community treatment plan.
- If the psychiatrist who issued the order is unable to carry out his/her responsibilities under the order, section 3 of the form shall be completed and a new copy of the form sent to the person who is the subject of the order, the representative, the rights advisor and each health care professional, person, and organization named in the community treatment plan.

1.30.40 Community Treatment Plan

- In accordance with *Section 40(2)(c)* of the Act, a community treatment plan shall be developed for a person subject to a community treatment order (see form **MHCTA-04**, Appendix I).

- Where a community treatment plan has been varied by the psychiatrist who is responsible for the general supervision and management of the plan or by a health care professional, person, or organization named in the plan a new community treatment plan shall be completed and sent to the administrator, the person who is the subject of the order, the patient representative, the rights advisor and each health care professional, person, and organization named the community treatment plan.

1.30.50 Authorized Patient Pass

- In accordance with *Section 37(2)* of the Act, a pass issued to an involuntary patient by the attending physician or designate permitting the accompanied patient to be absent from the unit for a specified period of time, subject to conditions, shall be issued on the approved form (See form **MHCTA-05**, Appendix I).
- A copy of the pass must be filed with the administrator. The original pass must be placed on the patient chart.

1.30.60 Order for the Apprehension and Conveyance of an Involuntary Patient Due to Unauthorized Leave

- In accordance with *Section 38(1)* of the Act, where an involuntary patient is absent from a psychiatric unit, without a pass or his or her pass has expired, the administrator may issue an order for the apprehension and return of the patient. The order shall be in the approved form (See form **MHCTA-06**, Appendix I).
- This order expires 30 days after the day it is issued.
- A copy of the order shall be provided to the administrator and the police.

1.30.70 Notification Advising a Person That a Community Treatment Order is No Longer in Effect

- In accordance with *Section 50(4)* of the Act, notice to a person who is the subject of the community treatment order that the order is no longer in effect and that he or she may live in the community without being subject to the order, shall be in the approved form (See form **MHCTA-07**, Appendix I).
- A copy of this notice shall be provided to the administrator (where appropriate) and to the patient representative, the rights advisor and each health care professional, person and organization named in the community treatment plan.

1.30.80 Order for the Apprehension, Conveyance and Examination of a Person who Failed to Comply to Community Treatment Order

- In accordance with *Section 51(1)* of the Act, an order for the apprehension, conveyance and examination of a person who failed to comply with the conditions of the community treatment order shall be issued in the approved form (See form **MHCTA-08**, Appendix I).
- This order shall expire 30 days after the date of the issuance of the order.
- A copy of the order shall be provided to the administrator and the police.

1.30.90 Authorization to Transfer to Another Psychiatric Unit

- In accordance with S*ection 75(3)* of the Act where a patient is transferred to another psychiatric unit an Authorization to Transfer form shall be completed in the approved form (See form **MHCTA-09**, Appendix I).
- A notice of this transfer shall be given to the administrator, the involuntary patient, his or her patient representative and the rights advisor.

1.30.100 Authorization to Transfer to Another Jurisdiction

- In accordance with S*ection 81(5)* of the Act when the attending physician authorizes the transfer of the patient to another jurisdiction it shall be on the approved form (See form **MHCTA-10**, Appendix I).
- A copy of this transfer shall be provided to the administrator, and notice given to the involuntary patient, his or her patient representative and the rights advisor.

1.30.110 Authorization to Transfer into the Province

- In accordance with S*ection 81(5)* of the Act when the physician authorizes the transfer of a patient into the province it shall be on the approved form (See form **MHCTA-11**, Appendix I).
- A copy of this transfer shall be provided to the administrator, and notice given to the involuntary patient, his or her patient representative and the rights advisor.

1.30.120 Order for Involuntary Psychiatric Assessment

- In accordance with S*ection 19* of the Act a judge may issue an order for an involuntary psychiatric assessment.

1.30.130 Involuntary Certification/Communication Checklist

- The regional health authority shall ensure there is a checklist for staff to complete which follows the patient through the certification process. This checklist will ensure the appropriate person fulfills his or her duties in relation to the certification process ensuring the appropriate timelines are met. This checklist

shall remain as part of the patient's file (See form **MHCTA-12**, Appendix I) and in the event of transfer, the checklist will transfer with the patient.

1.30.140 Application/Withdrawal of Application for Review by the Mental Health Care and Treatment Review Board

- In accordance with *Section 64* of the Act, application may be made to the Mental Health Care and Treatment Review Board:
    - To review the issuance of certification of involuntary admission or a certificate of renewal;
    - To review the issuance of a community treatment order or renewal; and,
    - To review the denial of a right as set out in *section 11 or 12* of the Act.
- This application may also be withdrawn (See form **MHCTA – 13**, Appendix I).
- A copy of the application should be sent to the administrator, the person and the patient representative.

1.30.150 Community Treatment Order (CTO) Checklist

- The regional health authority shall ensure there is a checklist for staff to complete which follows the patient through the community treatment order process. This checklist will ensure the appropriate person fulfills his or her duties in relation to the community treatment order process and ensuring the appropriate timelines are met. This checklist shall remain as part of the patient's file (See form **MHCTA-14**, Appendix I) and in the event of transfer, the checklist will transfer with the patient.

1.40 Administrative Files

The regional health authority shall ensure:

- An administrative file on all persons detained under the Act is opened and maintained by the regional health authority. The file shall be in the person's name and shall contain information related to the administration of the Act in relation to the person. This information will include but not be limited to copies of:
    - Certificates and renewal forms;
    - Passes;
    - Community treatment orders / variations / expirations / terminations / revocation orders; and,
    - Automatic applications to the Board.
- Administrative files shall be stored together and managed in a location to be determined by each regional health authority.

1.50 Notifying a Facility of Patient Conveyance

Under the Act, a patient may be conveyed to a facility when:

- A person is detained at a facility with one certificate completed and requires conveyance to another facility for a second assessment; or,

- A person may be fully certified with two certificates signed, but in a facility that is not a psychiatric unit and therefore will require immediate conveyance to a psychiatric unit. In these instances:
  - The attending physician or nurse practitioner at the first facility must contact the attending physician at the second facility and notify him or her of the plan to convey the patient; and,
  - Transfers must be completed as quickly as possible with no unnecessary delays.

1.60 Patient Passes

The regional health authority shall ensure:

- There is a written procedure for staff to follow for issuing a pass for involuntary patients. The pass (See form **MHCTA-5,** Appendix I) permits the accompanied patient to be absent from the psychiatric unit for a specified period of time, subject to the conditions specified in the pass. It must be issued on an approved form and signed by the attending physician or his or her designate (See Appendix F for a sample procedure which the regional health authorities may use as a guide in developing procedures related to issuing a patient pass).
- A copy of the pass must be filed with the administrator. The original pass must be placed on the patient chart.

1.70 Return of Person Detained and Released

Where a person is released from a facility under S*ection 23(1)* of the Act:

- The regional health authority shall, unless the detained person otherwise requests, arrange for the return of the person to the place where the person was when taken into custody or to another appropriate place. Ordinary discharges are not covered by this policy. It is only to be used when someone has been conveyed to the facility for an involuntary psychiatric assessment and a certificate is not signed or an assessment has not been conducted within 72 hours of arrival at the facility.
- All reasonable costs, including meals, accommodation and transportation during the return shall be the responsibility of the facility where the person is released.
- If the person requests a delay in return, this shall be accommodated up to seven days. The person is responsible for the all costs during that time frame.
- The regional health authorities must have a written procedure to follow in returning a person who has been detained and released (Appendix G is a sample procedure which the regional health authorities may use as a guide in developing procedures related to returning a person who has been detained and released).

1.80 Occurrences

The regional health authority shall have a written procedure to follow in the event of an occurrence. The following events are to be considered occurrences under the Act:

- Community treatment order not ordered due to inadequate resources;

- Renewals of certification or community treatment order not completed within established timeframes; and,
- Assessment of detained voluntary patient in a psychiatric unit not completed within 4 hours (*Section 34(3);*

  (See Appendix H for a sample procedure which the regional health authorities may use as a guide in developing procedures related to an occurrence.)

1.90 Evaluation

The regional health authority shall ensure mechanisms are developed to ensure monitoring reports are submitted and signed in accordance with the organization's quality initiatives.

2.0 Patient Representative

The Act requires that certain specified information be disclosed to the patient representative.

2.10 Rights of the Patient Representative

Patient Representatives (*Section 11(2)*) must:

- Be informed as soon as practicable by the regional health authority that:
    - The person is being detained in the facility for the purpose of an involuntary psychiatric assessment;
    - The detained person has the right to retain and instruct counsel without delay;
- Be given a copy of the certificate, order or other authorization under which the person has been apprehended or detained. Copies being mailed must be sent by Registered Mail and should never be faxed or scanned and emailed.

Where a person has been admitted as an involuntary patient or his or her status as an involuntary patient has been renewed, the administrator must provide a copy of all notices and other information required to be given to the involuntary patient to the patient representative. This includes notification (*Section 12)*:

- Of the person's status as an involuntary patient and the reason for the issuance of the certificates of the involuntary admission or the certificate of renewal;
- That the patient has the right to retain and instruct counsel without delay and consult in private either in person or by other means;
- That the patient or representative may apply to the Mental Health Care and Treatment Review Board for a review of the certificate of involuntary admission or the certificate of renewal; and,
- That the patient representative has the right to meet with the rights advisor.

During the application of diagnostic procedures or treatment the attending physician and another health care professional must (*Section 35(3)*):

- Consult with the patient representative;
- Provide him or her with an explanation of the purpose, nature, and effect of the procedure or treatment; and,
- Consider the patient representative's views on the procedure, treatment, alternatives and the manner in which they are to be provided.

Where a person is the subject of a community treatment order, the patient representative has the right to:

- Apply to the Board for a review of the issuance, renewal or revocation of the community treatment order (*Section 41(2)(c)*);
- Be given a copy of the issued or renewed community treatment order by either the administrator or psychiatrist (*Section 43)*;
- Be provided with written notice of the transfer of supervision and management responsibilities from one psychiatrist to another related to the community treatment order *(Section 44(3));*
- Be provided with written notice the community treatment order has expired and is not renewed by either the administrator or psychiatrist *(Section 47(2))*;
- Be provided with written notice of any variation in the community treatment plan by the psychiatrist who issued the community treatment order (*Section 49(2))*;
- Be given a copy of a written notice by the psychiatrist that the order is no longer in effect and that the person may live in the community without being subject to the order *Section 50(3)(c))*; and,
- Be provided with a notice of transfer where an involuntary patient is transferred to another psychiatric unit because it is in his or her best interest to be treated in another psychiatric unit or because he or she requires hospital treatment or other services that cannot be provided in a psychiatric unit (*Section 77)*.

3.0 Rights Advisor

Rights advisors report to the Director of Mental Health and Addictions, Department of Health and Community Services.

3.10 Responsibilities of the Rights Advisor

Under *Section 14* of the Act rights advisors are required:

- To offer advice and assistance in accordance with the Act to:
  - A person who is involuntarily detained in or admitted to a psychiatric unit;
  - A person who is residing in the community under a community treatment order or its renewal; and,
  - The patient representative.
- To meet in person or by other means, as soon as possible, and within 24 hours of a person's involuntary admission to a psychiatric unit or the issuance of a community treatment order, and after that at the request of the person or his or her patient representative;
- To contact a person who is an involuntary patient or who is under a community treatment order and his or her patient representative within 10 days of the first meeting between the rights advisor and the person.
- To explain the significance of the issuance or renewal of a certificate of involuntary admission or community treatment order to the person who is subject to the certificate or order;
- To communicate information in a neutral, non-judgmental manner;
- To meet as soon as is practicable in person or by other means with the patient representative and after that at the request of the patient representative;
- At the request of the person or his or her patient representative, assist the person in making application to the Board in accordance with the Act and regulations;
- At the request of the person or his or her patient representative, assist the person in obtaining legal counsel;
- At the request of the person or his or her patient representative, accompany the person to hearings of the Board;
- To maintain confidentiality; and,
- To perform other functions prescribed by the regulations.

3.20 Disclosure of Information to the Rights Advisor

The administrator must ensure that the rights advisor is given notice of (*Section 15(1):*

- A decision to admit or involuntarily detain a person in a psychiatric unit;
- The filing of each certificate in respect of an involuntary patient;
- The cancellation or expiration of a certificate of involuntary admission and the release of an involuntary patient from a psychiatric unit;
- The change in status of a voluntary patient to an involuntary patient; and,
- Applications to the Board for an automatic review of detention.

The administrator or attending psychiatrist shall ensure the rights advisor is given notice of *(Section 15(2))*:

- An application to the Board; and,
- The issuance, renewal, expiry, termination or revocation of a community treatment order;

The regional health authority must ensure the rights advisor is provided with a notice of transfer where an involuntary patient is transferred to another psychiatric unit because it is in his or her best interest to be treated in another psychiatric unit or because he or she requires hospital treatment or other services that cannot be provided in a psychiatric unit *(Section 77)*.

For community treatment orders, the administrator must ensure that the rights advisor is:

- Provided with a copy of the issued or renewed community treatment order by either the administrator or psychiatrist *(Section 43);*
- Provided with written notice of the transfer of supervision and management responsibilities from one psychiatrist to another related to the community treatment order (*Section 44(3))*;
- Provided with written notice that the community treatment order has expired and is not renewed by either the administrator or psychiatrist *(Section 47(2))*;
- Provided with written notice of any variation in the community treatment plan by the psychiatrist who issued the community treatment order *(Section 49(2));* and,
- Given a copy of a written notice by the psychiatrist that the order is no longer in effect and that the person may live in the community without being subject to the order *(Section 50(3)(c))*.

Please note that certificates, renewals, and patient file contents are not to be disclosed to a rights advisor. However, there are no limits on with whom a patient can share information from his or her file.

4.0 Health Professionals, Persons and Organizations Named in a Community Treatment Plan

The community treatment order will identify the health professionals, persons and organizations who have agreed in writing to provide treatment and support services to a person who is the subject of the community treatment order. In order for the Act to be implemented in a consistent manner, health professionals, persons and organizations named in a community treatment plan shall be aware of his or her responsibilities and rights according to the Act.

4.10 Responsibilities of Health Professionals, Persons and Organizations Named in a Community Treatment Plan

The health professionals, persons and organizations named in a community treatment plan shall have the following responsibilities under the Act *(Section 45):*

- Implement the community treatment plan to the extent described in the order;
- Provide reports (if required) to the psychiatrist who issued the community treatment order on the condition of the person who is the subject of the order;
- Advise the patient from the start of the community treatment order of his or her right to continue to "voluntarily" access the community mental health services and supports provided under the community treatment order for an indeterminate period of time even though the order may expire;
- Work to engage with the patient, while subject to the community treatment order, towards voluntary acceptance of treatment beyond the community treatment order;
- Educate the patient about the benefits of continued treatment beyond the community treatment order and the risks of discontinuing treatment; and,
- Not denying the patient access to continued treatment or placing the patient on a waitlist for the same treatment because they are no longer subject to a community treatment order.

4.20 Rights of Health Professionals, Persons and Organizations named in a Community Treatment Plan

The health professionals, persons and organizations named in a community treatment plan shall have the following rights under the Act. They shall be given:

- A copy of the issued or renewed community treatment order by either the administrator or psychiatrist *(Section 43);*
- Written notice of the transfer of supervision and management responsibilities (*Section 44(3));*
- Written notice that the community treatment order has expired and is not renewed by either the administrator or psychiatrist *(Section 47(2));*
- Written notice of any variation in the community treatment plan by the psychiatrist who issued the community treatment order *(Section 49(2))*; and,
- A copy of a written notice by the psychiatrist that the order is no longer in effect and that the person may live in the community without being subject to the order *(Section 50(3)(c))*.

DEPARTMENT OF HEALTH AND COMMUNITY SERVICES
Mental Health Care and Treatment Act – Provincial Policy Manual

Section 5.0 Mental Health Care and Treatment Review Board	Policy: 5.10 – 5.30
Effective Date: October 1, 2007	Revised: October 2015

5.0 Mental Health Care and Treatment Review Board

The Mental Health Care and Treatment Review Board comprises a minimum of 13 members, and is appointed by the Lieutenant-Governor in Council to hear and decide applications under the *Mental Health Care and Treatment Act.*

5.10 Decision Making

Three-member panels, comprised of a lawyer, physician and a community representative will hear applications for review. Each panel member has one vote. Decisions of the panel will be made by a majority vote.

5.20 Jurisdiction

The Board will review:

- Applications by the administrator made via automatic review pursuant to *Section 33 and 53(3)* of the Act;
- Applications by involuntary patients to review the issuance of certificates of involuntary admission or certificates of renewal;
- Applications by a person who is the subject of a community treatment order to review the issuance or renewal of the order; and,
- Applications by a person detained in a facility alleging a denial of a right set out in *Sections 11 or 12* of the Act.

5.30 Powers

A panel has all the powers, duties and immunities of a commissioner appointed under the *Public Inquiries Act*. It may:

- Require a witness to appear before it;
- Require the regional health authority to produce documents or records;
- Arrange for an involuntary patient or person subject to a community treatment order to be examined by a psychiatrist;
- Engage independent medical, psychiatric or other professional persons to present evidence and make submissions; and,
- Invite input from any other person who, in the opinion of the panel, has a material interest in or knowledge of matters relevant to the application.

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6.0 Peace Officers

6.10 Powers and Duties of the Peace Officer

The completion and signing of the first certificate of involuntary admission under S*ection 18* is authority for the peace officer (if acting under the authority of the certificate) to:

- Apprehend the person who is named in the certificate within seven days of the date of the signing of the certificate and convey him/her without his/her consent to a facility for a second involuntary assessment; and,
- To observe, detain, and control the person during apprehension and conveyance.

Where a judge issues an order (expires seven days after it is made) for an involuntary psychiatric assessment under S*ection 19*, a peace officer shall:

- Apprehend and convey the person to a facility for an involuntary psychiatric assessment; and,
- Observe, detain, and control the person during apprehension and conveyance.

Where a peace officer has reasonable grounds to believe a person meets the criteria set out in S*ection 20* of the Act, and it is not feasible in the circumstances to make an application for a judge's order, the peace officer may immediately apprehend and convey the person to a facility for an involuntary psychiatric assessment.

Where a peace officer apprehends a person under S*ubsection 18(2) or 19(4) or Section 20* of the Act, the peace officer shall inform the person:

- Of the reasons for his/her apprehension;
- That he/she is being taken to a facility for an involuntary psychiatric assessment; and,
- That he/she has the right to retain and instruct counsel without delay.

Where a peace officer apprehends and conveys a person to a facility for an involuntary psychiatric assessment under S*ection 18, 19 or 20* of the Act, the peace officer:

- May take reasonable measures, including the entering of premises and the use of physical restraint to apprehend the person and to take him/her into custody;
- Shall make the conveyance as soon as practicable and by the least intrusive means possible without compromising the safety of the person or public;
- Shall provide the person at the facility conducting the assessment with:
    - The first certificate of involuntary admission where the person is apprehended and conveyed under S*ubsection 18(2)*;

- The judicial order where the person is apprehended and conveyed under *Subsection 19(4)*;
- A written statement from the peace officer who apprehended and conveyed the person under *Section 20*. This written statement shall set out:
  - The name of the person conveyed, if known;
  - The date, time and place the person was apprehended; and,
  - The grounds on which the peace officer formed his or her belief and any other information relating to the circumstances which led to the taking of the person into custody.

- Shall remain at the facility and retain custody of the person who has been apprehended until the psychiatric assessment is completed or the person conducting the assessment advises that continuing custody is not required.

Where an administrator issues an order to a peace officer under *Subsection 38(2)* of the Act to apprehend a patient who is absent from a psychiatric unit (unauthorized leave), the order is authority for the peace officer to:

- Apprehend the person named or described in the order and return him or her to the psychiatric unit; and,
- Observe, detain and control the person during his/her apprehension and return to a psychiatrist or a psychiatric unit.

Where a psychiatrist issues an order to a peace officer under *Subsection 51(1)* of the Act to apprehend and convey a person who failed to comply with the conditions of the community treatment order, the order is authority for the peace officer to:

- Apprehend the person named in the order and convey him or her to a facility named in the order for a psychiatric assessment;
- Observe, detain and control the person during his or her apprehension and conveyance to the facility; and,
- Take reasonable measures, including the entering of premises and the use of physical restraint to apprehend the person and to take him or her into custody.

7.0 The Department of Health and Community Services

7.10 Distribution of Manual and Forms

The Department of Health and Community Services will ensure this policy manual and the associated forms are up to date and displayed on the departmental website. Forms in the manual are approved forms as required by the Act. The manual includes the following forms in Appendix I.

- MHCTA-01 Certificate of Involuntary Admission
- MHCTA-02 Certificate of Renewal
- MHCTA-03 Community Treatment Order
- MHCTA-04 Community Treatment Plan
- MHCTA-05 Authorized Patient Pass
- MHCTA-06 Order for the Apprehension and Conveyance of an Involuntary Patient due to Unauthorized Leave
- MHCTA-07 Notification Advising a Person that a Community Treatment Order is No Longer in Effect
- MHCTA-08 Order for the Apprehension, Conveyance and Examination of a Person who Failed to Comply to Community Treatment Order (CTO)
- MHCTA-09 Authorization to Transfer to Another Psychiatric Unit
- MHCTA-10 Authorization to Transfer to Another Jurisdiction
- MHCTA-11 Authorization to Transfer into the Province
- MHCTA-12 Involuntary Certification/Communication Checklist
- MHCTA-13 Application/Withdrawal of Application for Review by the Mental Health Care and Treatment Review Board
- MHCTA-14 Community Treatment Order (CTO) Checklist

7.20 Review of Manual

The Department of Health and Community Services will ensure the manual is reviewed at least once every three years. Specific issues will be reviewed as they arise. Upon review and consultation, any changes and additions will be updated in the manual, forwarded to the regional health authorities, and updated on the website.

7.30 Evaluation of Act

The Department of Health and Community Services will ensure the Act is monitored on a yearly basis as per evaluation criteria with a view to preparing for the ministerial review which must be conducted every five years.

Appendix E: Community Treatment Order Requirements Across Provinces

Community Treatment Order Comparison – Requirements

	Saskatchewan	Ontario	Nova Scotia	Newfoundland and Labrador	Alberta	Manitoba [a]
LEGISLATION	*Mental Health Services Act*	*Mental Health Act*	*Involuntary Psychiatric Treatment Act* [b]	*Mental Health Care and Treatment Act*	*Mental Health Act*	Mental Health Act
REQUIREMENTS						
1. Period prior to CTO	2 years s. 24.3(1)(a)(ii)	3 years s. 33.1(4)(a)	2 years s. 47(3)(iv)	2 years s. 40(2)(b)	3 years s. 9.1(1)(b)(i)	2 years s. 46(2)
2. Prior hospitalization [c]						
(a) type	Voluntary or Involuntary s. 24.3(1)(a)(ii)(A)	Any type s. 33.1(4)(a)(i)	Involuntary s. 47(3)(iv)(A), (B)	Involuntary s. 40(2)(b)(i)	Involuntary, equivalent, or none (“custodial institution”). s. 9.1(1)(b)(i)	Any type. Only references being a “patient”. s. 46(2)(a), (b)
(b) days OR	N/A	30 s. 33.1(4)(a)(i)	60 s. 47(3)(iv)(A)	N/A	“the person has on 2 or more occasions, or for a total of at least 30 days” s. 91(1)(b)(i)	60 (whether consecutive or not) s. 46(2)(a)
(c) admissions	At least one occasion s. 24.3(1)(a)(ii)(A)	2 s. 33.1(4)(a)(i)	2 or more s. 47(3)(iv)(C)	3 or more s. 40(2)(b)(i)		Three or more. s. 46(2)(b)

3. Previous CTO (alternative to prior hospitalization)	Yes s. 24.3(1)(a)(ii)(B)	Yes s. 33.1(4)(a)(ii)	Yes s. 47.3(iv)(C)	Yes s. 40(2)(b)(ii)	Yes s. 9.1(1)(a)(iii)	Yes s. 46(2)(c)
4. Length of CTO	Valid for period specified in CTO, maximum of six months; renewal is contemplated and can be for a maximum of six months (Note: there is no reference to a limit on the number of renewals) [3]	Six months unless renewed (further six months) or terminated in accordance with the Act. s. 33.1(11)	Six months unless renewed (further six months, unlimited renewals) or terminated in accordance with the Act. s. 51	Six months unless renewed (further six months, unlimited renewals) or terminated in accordance with the Act s. 47(1)	Six months unless renewed (further six months, unlimited renewals) or cancelled in accordance with the Act s. 9.2	Not more than six months; may be extended for additional periods of not more than six months. May be cancelled. s. 46(9)

[3] If CTO is validated by a designated physician and not by a psychiatrist, it is valid for 72 hours; a CTO supported by a physician may be renewed if a further certificate in support of a CTO is issued by a psychiatrist - renewal in such instance is then valid for a maximum of 6 months – See s. 24.5(1.1) through (1.3).

4. Examination(s)	2 – 1 psychiatrist to issue CTO and a different psychiatrist to issue a certificate in support of a CTO (See s. 24.4 (Note: where a different psychiatrist is not available,a physician designated under the Act may be used). For a renewal of a CTO, only one examination is required as a certificate in support of a CTO is not required on renewal (See S. 24.4(4))	1 physician s. 33.1(1)	1 psychiatrist s. 47(2)	1 psychiatrist s. 40(2)	2 physicians, one of whom must be a psychiatrist s. 9.1(1)	1 psychiatrist s. 24.2(1)

5. Consent needed	No	Yes, from person or his or her substitute decision maker s. 33(1)(4)(f)	Yes. Involuntary person's substitute decision maker. s. 47(3)(b)	No.	Yes, from person or his or her substitute decision maker. Not required where risk of harm to others. s. 9.1(1)(f)	Yes, from person or if not mentally competent to consent, from the person authorized to make treatment decisions on the patient's behalf. s. 46(3)(b)
REQUIRED CONDITIONS FOR TREATMENT:						
(a) Exist in the community	Yes s. 24.3(1)(a)(iv)(A)	Yes ("available in the community" s. 33.1(4)(c)(v)	Yes s. 47(3)(a)(v)(A)	Yes s. 40(2)(a)(iv)(A)	Yes s. 9.1(1)(d)	Yes s. 46(5)(d)
(b) Available to the person	Yes s. 24.3(1)(a)(iv)(B)		Yes s. 47(3)(a)(v)(B)	Yes s. 40(2)(A)(iv)(B)	Yes s. 9.1(1)(d)	(Yes) "[c]an and will be provided in the community" s. 46(5)(d)
(c) Will be provided to the person	Yes s. 24(1)(a)(iv)(C)	(Community treatment plan must provide	Yes s. 47(3)(a)(v)(C)	Yes s. 30(2)(a)(iv)(C)	Yes s. 9.1(1)(d)	Yes. (See above).

		names of people that have agreed to provide treatment or care and supervision under the community treatment plan)				
Person is capable of complying with CTO	Yes s. 24.3(1)(vi)	Yes. (“able to comply”) s. 33.1(4)(c)(iv)	No reference.	Yes s. 40(2)(a)(v)	Yes (“able to comply”) s. 9.1(1)(e)	Yes s. 46(5)(c)
Provisions for non-compliance	Yes s. 24.6(1)	Yes s. 33.3(1)	Yes s. 56(1) (“failed in a substantial or deleterious manner to comply with....”)	Yes s. 51(1) (“failed to comply with a condition of the community treatment order”)	Yes s. 9.6(1) (“failed to comply with the community treatment order”)	Yes s. 48(1) (“failed tom comply with the psychiatric treatment described in the leave certificate or failed to attend the required appointments..”
Alternate designated health professional to issue certificate	Yes s. 24.31				Yes s. 9.7(1)	No

Provisions where issuing physician/psychiatrist cannot carry out obligations under CTO		Yes s. 33.5(2)	Yes s. 53(2)	Yes s. 44(2)		
Person, as result of mental disorder, does not have full capacity to make treatment decisions	Yes s. 24.3(1)(a)(v) ("is unable to fully understand and to make an informed decision…"	* Check- s. 15(1) and (1.1)	Yes s. 47(3)(a)(iii)	Yes s. 40(2)(a)(iii)	No specific reference. Note 9.1(1)(f)(i)- this is reference of competence in terms of ability to provide consent to order.	No specific reference. Note s. 46(3)(b)- refers to competence to consent to issuance of proposed leave certificate and treatment plan
Expiration/Revocation/ Cancellation	s. 24.5(2): Where CTO has expired, attending physician must notify in writing that CTO is no longer in effect. s. 24.5(3): Where attending believes person subject to CTO	s. 33(11): Expires after six months. s. 33.2: Physician can terminate CTO where determines that person is able to live in community without being subject to order.	s. 51: Expires after six months. s. 55(3): Psychiatrist can terminate CTO where circumstances for issuance no longer exist. s. 56(3): Psychiatrist can examine person	s. 47(2)- expires. Psychiatrist provides written notice that it is no longer in effect to person, representatives, health care professionals. s. 51(1): Revocation	Expires after 6 months unless renewed or cancelled (s. 9.2); Psychiatrist may cancel at anytime in accordance with regulations if 9.1(1)(b)-(d) criteria no longer apply[4] s. 9.6(4)(a): If failed to comply with CTO, psychiatrist can	**Release after examination for non compliance?** s. 47(2): Psychiatrist can revoke leave certificate where requirements for certificate are no longer me; pt may live in community without being subject to CTO.

[4] Regulations checked; nothing included for cancelling CTO

	no longer meets criteria, can issue order revoking CTO then in effect.	s. 33.3(4)(a): Physician can issue order for examination; one outcome is determination that person should be released without being subject to CTO. s. 33.4: Person subject to CTO can withdraw consent; must undergo examination, one outcome is released without CTO	subject to CTO where believe that person has filed to comply with CTO; one out come of this is that person can be released without being subject to CTO.	where there is reasonable grounds for believing the person has failed to comply- termination is one outcome (or can be involuntary admission). s. 50- can terminate after assessment at request of person subject to order.	order person to be apprehended and undergo examination. One out come of this is that person can be released and CTO cancelled.	s. 48(3): Attending psychiatrist may cancel leave certificate where belief that pt may constitute danger or suffer mental/physical deterioration if in community; and pt has failed to comply with treatment described in certificate or attend appointments. Person can then undergo examination. One outcome is that they are released without a further certificate.
Duty to provide care/ Accountability/ Management	Yes. s. 24.7: Where CTO is validated (with a certificate), attending physician must endeavour with resources reasonably	Yes. s. 33.5(1): Issuing/renewing /appointed physician is "responsible for the general supervision and	Yes. s. 53(1): Psychiatrist that issues/renews CTO is "responsible for the general supervision and	Yes. s. 44(1): Psychiatrist that issues/renews CTO is "responsible for its general	No.	No.

	available to “provide the person who is the subject of the order with services so that the compulsory treatment or care and supervision of the person will no longer be required.”	management of the order”. s. 33.5(3): Person who agrees to provide treatment/care/supervision under CT plan “shall indicate his or her agreement in the plan and is responsible for providing the treatment or care and supervision in accordance with the plan.” s. 33.5(4): Other person named in CT plan is responsible for implementing the plan to the extent indicated in it.	management of order.	supervision and management.” s. 45(1): Psychiatrist may require reports from those responsible for providing treatment or care and supervision under CT plan. s. 45(2): Health care professional, person or organization providing treatment or care and supervision “is responsible for implementing the community treatment plan to the extent described in the order.”		
Treatment plan	s. 24.3(1)(c): CTO must “describe	s. 33.1(4)(b): CTO can only be	s. 47(3)(d): CTP must describe	s. 41(2)(d): CTO must describe	S. 9.2(2)(e): CTO must set out the	s. 46(3): A leave certificate may only

	the services that will be provided to the person and the treatment that is recommended for the person”	issued where person/SDM/physician/other health care provider have developed a CT plan; s. 33.6(c): CTO must contain description of CT plan; s. 33.7: Required contents for CT plan	services that will be provided “and the community treatment plan that is recommended for the person”; s. 48: Contents of CT plan	community treatment plan; s. 42: Contents of community treatment plan	treatment or care referred to in 9.1(1)(c) (the person will cause harm or suffer mental or physical deterioration if the person does not receive “continuing treatment or care while living in the community”	be issued if patient/representative/psychiatrist and other health professionals involved in pt’s care or treatment “develop a treatment plan for the patient that will form the basis of the leave certificate”; 46(6)(b): Leave certificate must include description of treatment or care and supervision to be provided to pt;
Purpose clause (ON only?)	No.	Yes.	No.	No.	No.	No.
Rights advisor	Yes s. 10 - “the Minister shall	Yes. Note section 1(1) of the Act defines “rights advisor”	Yes. s. 61(1)(c) “patient advisor service” may offer advice and assistance to a	s. 13: Rights advisor appointed by minister.	No.	No but s. 46(4) says psychiatrist shall inform pt of his or her right to have a representative

	appoint one or more persons to be official representatives for each region to assist patients in understanding their rights and obligations pursuant to this Act".	as not including "a person providing treatment or care and supervision under a community treatment plan." s. 33.1(4)(e): Physician must be satisfied that pt or SDM "have consulted with a rights advisor and have been advised of their legal rights" before issuing CTO. (Exceptions in s. 33.1(5)).	patient who is on a CTO.	s. 14(1) and (2): Rights advisor offers assistance to a person living in the community under a CTO. s. 14(2)(a): Rights advisor meets asap with person residing in community under CTO. (Administrator or attending psychiatrist informs rights advisor). s. 41(3): CTO tells pt that he or she has the right to meet with a rights advisor		involved in the development of a treatment plan.
Obligations of person (subject to order)	No positive obligation. Consequences if does not comply	s. 33.1(6): CTO contains undertaking by pt to comply with	s. 47(3)(e): CTO shall state that the person is to submit to medical treatment, attend	s. 42(c): CT plan contains the obligations of	No positive obligation. Consequences in the	s. 46(7): Obligation on pt to attend appointments and comply with

	(See s. 24.6 re: compliance). s. 24.3(1)(d): CTO must state that the pt is to submit to medical treatment, attend appointments, etc. Note that CTO is not signed by pt or SDM.	obligations set out in CTO. s. 33.1(9): If a person or his or her SDM consents to a CT plan, that person shall attend appointments, comply with CT plan described in CTO.	appointments. Note that CTO is not signed by pt or SDM. s. 48(c): CT plan must contain any obligations on person subject to CTO	the person who is the subject of the CTO	event of non-compliance.	treatment described in the certificate. s. 46(6): Certificate must include description of pt's obligations.
Order for examination	s. 24.6(1): Where person fails to comply with CTO and refuses to submit to a psychiatric examination to ascertain	s. 33.3(1): Physician that issued or renewed CTO has reasonable cause to believe person subject to CTP has failed with	s. 56(1): Psychiatrist has reasonable cause to believe that person subject to CTO has failed in a substantial or deleterious	s. 51(1): Psychiatrist responsible for management and supervision of CTO has reasonable grounds to	s. 9.6: Psychiatrist issues where reasonable grounds to believe person subject to CTO has failed to comply with CTO. Notice must be given first.	s. 48(1): Psychiatrist may cancel certificate where patient constitutes danger to self or other or where pt has failed to comply with treatment described

	whether he or she should be admitted to a mental health centre, the attending physician or prescribed health professional may order that the person be apprehended and conveyed to a place for the examination to take place.	obligations can issue order for examination. 33.3(1.1): Does not cancel CTO. 33.3(2): Need reasonable efforts first to locate and inform	manner to comply with that person's obligations, psychiatrist requests peace officer to take person into custody and take to psychiatrist. s. 56(2): Need reasonable efforts to locate person and notify.	believe person has failed to comply with a condition of CTO can issue order in approved form to a peace officer. s. 51(2): Psychiatrist cannot issue order unless person refuses to submit to assessment and reasonable efforts made to inform and provide assistance.		in leave certificate and efforts made to locate and inform pt, provide assistance, etc. Cancellation of certificate then sufficient authority for peace officer to take pt into custody and to facility (s. 48(2)) and examination happens upon return (s. 48(9).
Withdrawal of consent	No provisions.	s. 33.4(1): Person subject to CTO or SDM may withdraw consent to CT plan by giving	s. 47(3)(b): SDM consents to person being placed on CTO. s. 55(1): SDM can request	No specific consent provisions? s. 50(1): When CTO is in effect, where pt	s. 9.5: A psychiatrist may at any time cancel a CTO in accordance with regs if any of the	s. 47(2): Psychiatrist can revoke leave certificate if it is determined that the criteria are no longer met.

		physician who issued or renewed the notice a notice of intention to withdraw consent. - Physician must then assess person, etc.	psychiatrist to review pt to determine if pt is able to continue to live in community without being subject to order.	requests, psychiatrist must conduct assessment to determine if person is able to continue living in the community without being subject to the order.	criteria in s. 9.1(1)(b) to (d) cease to apply. - Requirement for consent is s. 9.(1)(f).	s. 46(5) sets out "criteria" s. 46(3)(b) provides that in order for leave certificate to be issued, pt consents to issuance and proposed treatment plan or SDM does.
Responsibilities of named people (other than person/patient)	s. 24.3(1)(e): CTO must identify the names of the persons authorized by the regional director who will ensure that the person subject to CTO will receive the services that he or she requires See also the provisions regarding the official	s. 33.5: Accountability of physician that issues or renews CTO and people who agree to provide treatment or care and supervision, and other people named in CT plan (including person subject to plan). (This is not in a form but instead a general	CTO and CTP must identify those who have agreed to provide treatment and their obligations under the plan. s. 53(1): Psychiatrist that issues or renews CTO is responsible for general supervision and management of order.	s. 40(2): person, psychiatrist, health profession, other involved in treatment or care and supervision have developed plan and have agreed to be named in the plan. s. 42(1)(e): CTO identifies person who has agreed to accept responsibility	s. 9.1(2)(f): CTO must identify person responsible for supervision of CTO and any reporting obligations in respect of the CTO in accordance with the regulations. Regulations: s. 6(1): Person named in a CTO as a provider of treatment or care must report any failure by pt to comply with the terms of the CTO by completing form and	s. 46(3): Pt, pt's relatives, psychiatrist and other health professionals must develop treatment plan

	representative in the Act - e.g. s. 33(2) requires the official representative to visit the patient, advise the patient of his or her right of appeal, and provide any assistance deemed necessary to enable the patient (or relative/proxy/guardian) to initiate an appeal.	accountability clause).		for general supervision and management of CT Plan and sets out the reporting obligations of that person. s. 42(1)(f): identifies health professionals, persons, organizations who have agreed to provide treatment and support services and sets out their reporting obligations. s. 44(1): Psychiatrist that issues CTO is responsible for its general supervision and management.	submitting to appropriate RHO.	

				s. 45(1): Psychiatrist may require reports on condition of person subject to CTO from health care professionals, persons and organizations responsible for providing treatment or care and supervision. s. 45(2): (people named above) responsible for implementing CT Plan to extent described in order.		
Vary plan	No provisions	s. 33.1(13): Upon termination of CTO, parties may enter into a	s. 49: Psychiatrist may vary any part of the CT Plan.	s. 49: Psychiatrist may vary CT plan or health care	s. 9.4: CTO may be amended by a psychiatrist in	s. 47(2): After review of leave certificate, psychiatrist can

		subsequent CT Plan. s. 33.2(4): Where assessment occurs when non-compliance, physician can issue another CTO where person or SDM consent. (And 33.4 where assessment after withdrawal of consent).	s. 56(3): Where assessment after non-compliance, psychiatrist can issue another CTO where person or SDM consent	professional, person or organization named in CT plan, with approval of psychiatrist, can vary CT Plan. s. 51(5): Where failure to comply, assessment conducted to determine if (among other options), CTO should be continued, with any necessary variations.	accordance with the regulations.	amend requirements of leave certificate.
Services unavailable	s. 24.5(3): Attending physician can revoke CTO where criteria prescribe in 24.3(1)(a) are no longer met.	None.	s. 57(1): Where services required for CTO become unavailable, psychiatrist shall terminate CTO and perform notifications; review person's condition	None.	s. 9(5): Psychiatrist may cancel order where 9.1(1)(d)- availability of treatment- ceases to apply.	s. 47(2): If criteria no longer met, psychiatrist shall revoke leave certificate. S. 46(5)(d)- criteria includes "the treatment or care and supervision described in the leave exist in the community and

	(S. 24(3)(1)(a)(iv)(A)- requires that services exist in the community.)					can and will be provided in the community."
Board review	s. 33 – a person that is the subject of a CTO must receive notice of: the existence and function of the review panel, the name and address of the chairperson of the panel, and the right of appeal to the review panel pursuant to s. 34. Official representative also meets with the patient to advise of right of	None?	s. 58(1): Person subject to CTO or SDM can apply to Review Board to inquire into whether the criteria for issuing or renewing a CTO have been met.	s. 53(1): Person subject to CTO or his or her representative may apply to the board to review whether the criteria for issuing or renewing an assisted CTO are met.	None?	None?

	appeal (see above). See s. 34 for more information re: appeals.					

[a] Note that Manitoba's legislation refers to the ability to grant "leave certificates". These are very similar to community treatment orders. The main difference between the Manitoba leave certificate and the CTOs in other jurisdictions is that the MB's leave certificates can only be granted to a "patient" as opposed to a "person".
[b] NS also has certificate of leave (s. 43)
[c] Assumption that when "detained" is used that the prior hospitalization is involuntary.