MHCTA
Education Sessions
Labrador-Grenfell Health

Newfoundland Labrador

MENTAL HEALTH

Care & Treatment Act

Motivation for change

- The previous mental health legislation was enacted in 1971
- There was a need to focus on the rights of people who are involuntarily detained under the Act
- To revise the ***eligibility criteria*** that are used to determine what situations / individuals benefit from the authority of the Act
- Amendments to the Act came into force on June 5, 2014

MENTAL HEALTH
Care & Treatment Act

Implementation

- Mental Health Care and Treatment Act was passed by House of Assembly, December 11, 2006
- The Act came into effect on Oct. 1, 2007
- The section related to Community Treatment Orders came into effect on January 1, 2008
- Amendments to the Act came into force on June 5, 2014

MENTAL HEALTH
Care & Treatment Act

Purpose of the Act (s. 3)

1. To provide treatment & protection for persons suffering from a **severe mental disorder** to the degree that:
   - *They are at risk of harming themselves / others; or,*
   - *They are likely to experience **substantial mental or physical deterioration without treatment.***
2. *To provide for apprehension, treatment etc in least restrictive manner to achieve purposes above*
3. To provide for the rights of persons who come under the act

MENTAL HEALTH

Care & Treatment Act

Key Points

1. Eligibility criteria *and process for involuntary admission*
2. *"Facilities" and "psychiatric units"*
3. Provision of a range of patient / individual rights & protections but substitute decision-making not available
4. Expanded roles for nurses, nurse practitioners & peace officers
5. *Treatment*
6. Mandatory review of the Act within 5 years
7. Provision of Community Treatment Orders
8. Changes to the role and operation of MHCTA Review Board

MENTAL HEALTH

Care & Treatment Act

1) Certification Eligibility Criteria *(s. 17)*

- The individual is suffering from a **mental disorder** *s. 2(k)*, and
- Is likely to cause harm to self or others, or ***is likely to suffer substantial mental or physical deterioration without treatment, and***
- Is unable to **fully** appreciate the nature & consequences of the disorder & make an informed decision on treatment & care, and
- **Needs treatment** which is only available in a psychiatric unit.

MENTAL HEALTH

Care & Treatment Act

DEFINITION OF MENTAL DISORDER, s.(2)(k)

- “mental disorder” means a disorder of thought, mood, perception, orientation or memory that impairs
- (i) judgement 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”

2) Facilities and Psychiatric Units

- Facility – a place where a psychiatric assessment may be conducted and includes a physician's office (ie St. Anthony, Labrador City, Goose Bay)
- Psychiatric Unit – a hospital or part of a hospital 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

3) Rights based approach

- The Act addresses an individual's *procedural* right to (s. 11)
  - Know where & why he / she is being detained
  - *Be given a copy of certificate, order, or other authorization*
  - Access a telephone & visitors
  - Send & receive correspondence
  - Retain & instruct counsel
  - Access their representative and rights advisor
  - Have input (& representative input) into treatment decisions

The Rights of an Involuntary Patient

An involuntary patient is a person who has received a psychiatric assessment, has been certified according to the *Mental Health Care and Treatment Act*, and has been admitted to a psychiatric unit as an involuntary patient.

As an involuntary patient, an individual's rights include:

- Meeting and speaking with a lawyer in private at any time either in person or by other means;
- Having reasonable access to a telephone to make or receive calls;
- Having visitors during regular visiting hours;
- Meeting in person or by telephone with a rights advisor who will explain the individual's rights under the Act;
- Meeting and speaking with a patient representative;
- Being able to write and send letters, and have reasonable access to mail sent to the individual;
- Being told why a certificate of involuntary admission has been issued or renewed;
- Receiving a copy of the certificate of involuntary admission or certificate of renewal;
- Applying to the Mental Health Care and Treatment Review Board for a review of a certificate of involuntary admission or renewal;
- Receiving information describing the review process including the Review Board's function, its address, and an individual's and patient representative's right to act on the individual's behalf in the review process; and,
- Having an interpreter if needed.

MENTAL HEALTH
Care & Treatment Act

Newfoundland
Labrador

Rights Advisors (s. 13, 14,15)

- *Appointed by Minister (not patient). Accessed through the following telephone #: 1-888-546-1222*
- Responsible for meeting with people involuntarily hospitalized or placed on a CTO, and their patient representatives
- Must meet with the individual and his/her representative within 24 hours of the person becoming certified, and follow up with them within 10 days after the first meeting.
- Responsible for providing information and advice about an individual's status as an involuntary patient, and his/her rights set out in the Act.

MENTAL HEALTH

Care & Treatment Act

Patient Representative (s. 2(1)(t))

…a person, other than a rights advisor, who *is 19 or more and is "mentally competent", who* has been designated by ***the patient***, and who has agreed to act on behalf of, a person and may include the next of kin, legal counsel or guardian.

If no one is designated the representative shall be the next of kin (s. 2(m)) unless patient objects. The patient can refuse to have a representative

4) Physician/ Nurse Practitioners

- Can sign the first certificate (s. 18)
- Provides patient with rights including copy of first certificate AND copy to representative (s. 11)
- May order transport, treatment, medication or other intervention as appropriate (s. 18)
- Arranges for second certificate examination

Peace Officer (RNC/RCMP)

- Can apprehend individual (s. 20) *–on "reasonable grounds"*
- Must advise individual detained or apprehended under the Act of their rights (Section 10)
- *Stay till told by the person conducting the psychiatric assessment that custody is no longer required (s. 21(4))*

RCMP Form (BD4448)

Royal Canadian Mounted Police / Gendarmerie royale du Canada
B Division / Division B

Mental Health Care and Treatment Act Report

File No.:

Escort/Patient/Detainee

Surname: | Given 1: | Given 2:

DOB: | Sex: Male Female | Child/Youth | CYFS Notification Required: Yes No

CYFS Contacted: Yes No | CYFS Representative Notified:

Parent/Guardian: | Contacted: Yes No

Civic Address: | Phone No.:

Type of Dispatch Call: | Who Contacted Police:

Location Escorted From:

Location Escorted To:

Reasons For Detention:

Additional Information (Check all boxes that apply)

Suicide Risk Yes No | Security Risk Yes No | Medical Risk Yes No

Danger Issues

Active to Self	Suicidal Thoughts	Suicidal Act	Self-mutilation
Active to Others	Homicidal	Aggressive	Weapons Present
Passive to Self	Poor Self Care	Poor Judgment	Clothing Inappropriate for Weather

Medical Information

Family Doctor: | Hospital Associated With:

Psychiatrist: | Other Professional Agency:

Are they taking medications? Yes No (If Yes) List:

Pharmacy Name and Number:

Appearance/Behavior

General	Cooperative/Polite	Rude	Proper Clothing	Maintains Eye Contact
Hygiene	Clean	Dirty	Body Odor	Malnourished
Activity	Slow	Agitated	Restless/Fidgety	Abnormal Movements

Thinking

Disorganized Thinking	None	Mild	Moderate	Severe
Abnormal Speech	Rapid	Loud/Swearing	Few Words	Other
Odd Beliefs	Paranoid	Grandiose	Bizarre	Other
Hallucinations	Voices	Visions	Abnormal Sensations	Other

Describe other:

Mood

Rapid change of mood | Mood not appropriate for situation

Happy | Sad | Angry | Flat | Anxious

Orientation (Ask and record responses)

Day: | Month: | Year: | Location:

Dwelling

Food in Fridge | Rotten Food | Clean | Dirty | Disorganized | Fire Hazard

Alcohol Use

Admitted | Quantity: | Suspected | Comments:

Drug Use

Admitted | Suspected | Drug Type: | Cocaine | Marijuana | Other:

Action

No Action | Voluntary to Hospital | Involuntarily Committed

Follow up with Professional | Name:

Arrested Charged | Charges:

Comments

Completed By: | Reg. No.: | Date:

Completed By: | Facility: | Date:

RCMP GRC BD4448 (2014-08)

Canada

MENTAL HEALTH

Care & Treatment Act

RNC Form (257)

Mental Health Care and Treatment Act Template
(Report/Escort Form)

RNC File#: -

Escort/Patient/Detainee

Surname:	G1:	G2:
DOB:	Sex: ☐ Male ☐ Female ☐ Child/Youth	CYFS Notification Required: ☐ Yes ☐ No
CYFS Contacted: ☐ Yes ☐ No	CYFS Representative Notified:	
Parent/Guardian:		Contacted: ☐ Yes ☐ No
Civic Address:		Phone #:
Type of Dispatch Call:		Who Contacted Police:
Location Escorted From:		
Location Escorted To:		
Reason(s) For Detention:		

Additional Information (*Check all boxes that apply*)

Suicide Risk ☐ Yes ☐ No	Security Risk ☐ Yes ☐ No	Medical Risk ☐ Yes ☐ No

Danger Issues

Active to Self	Active to Others	Passive to Self
☐ Suicidal Thoughts	☐ Homicidal	☐ Poor Self Care
☐ Suicidal Act	☐ Aggressive	☐ Poor Judgment
☐ Self-mutilation	☐ Weapons Present	☐ Clothing Inappropriate for Weather

Medical Information

Family Doctor:	Hospital Associated With:
Psychiatrist:	Other Professional Agency:
Are they taking medications? ☐ Yes ☐ No	(If Yes) List:
Pharmacy Name and Number:	

Appearance/Behavior

General	☐ Cooperative/Polite	☐ Rude	☐ Proper Clothing	☐ Maintains Eye Contact
Hygiene	☐ Clean	☐ Dirty	☐ Body Odor	☐ Malnourished
Activity	☐ Slow	☐ Agitated	☐ Restless/Fidgety	☐ Abnormal Movements

Thinking

Disorganized Thinking	☐ None	☐ Mild	☐ Moderate	☐ Severe
Abnormal Speech	☐ Rapid	☐ Loud/Swearing	☐ Few Words	☐ Other
Odd Beliefs	☐ Paranoid	☐ Grandiose	☐ Bizarre	☐ Other
Hallucinations	☐ Voices	☐ Visions	☐ Abnormal Sensations	☐ Other

Describe Other:

Mood

☐ Rapid change of mood ☐ Mood not appropriate for situation

☐ Happy ☐ Sad ☐ Angry ☐ Flat ☐ Anxious

Orientation (*Ask and record responses*)

Day:	Month:	Year:	Location:

Dwelling

☐ Food in Fridge ☐ Rotten Food ☐ Clean ☐ Dirty ☐ Disorganized ☐ Fire Hazard

Alcohol Use

☐ Admitted Quantity: ☐ Suspected Comments:

Drug Use

☐ Admitted ☐ Suspected Drug Type: ☐ Cocaine ☐ Marijuana ☐ Other:

Action

☐ No Action	☐ Voluntary to Hospital	☐ Involuntarily Committed
☐ Follow up with Professional	Name:	
☐ Arrested/Charged	Charges:	

Comments

Completed By:	Reg#:	Date:
Received By:	Facility:	Date:

RNCP 257
Revised 2014/07

* White Copy To Be Presented To Health Care Official/Yellow Copy To Be Attached To File*

MENTAL HEALTH

Care & Treatment Act

5) Treatment and Timelines

- First Certificate
- Second Certificate

MENTAL HEALTH

Care & Treatment Act

First certificate *consequences (s. 18)*

- Person can be apprehended and conveyed without consent to a facility, *preferably a psychiatric unit,* for the second involuntary psychiatric assessment by a psychiatrist.
- Person can be observed, detained and controlled during his or her apprehension and conveyance
- Person who signed first certificate can authorize treatment
- Person can be detained, restrained, treated and observed without his or her consent for a period of up to 72 hours *from the time of arrival in the facility or psychiatric unit .*
- *Conveyance should happen as soon possible but the first certificate is valid for 7 days (e.g. weather)*

Second Certificate (s.22)

- The psychiatrist signing has personally conducted a psychiatric assessment within past 72 hours (48 hours by policy).
- Time and date of assessment
- *It is recommended where appropriate that the second certificate be conducted by a psychiatrist at a psychiatric unit (s. 23)*

6) Mandatory Review of the Act

- Your observations of how this process unfolds are important. The Act will be reviewed every **five years**. It is important to recognize what is working well and what needs to be improved.

7) Community Treatment Orders

- Provides a treatment option for a difficult-to-serve group in the NL system
- Involves mandated treatment and care in the community under the supervision of the treating psychiatrist and *usually* an assertive case management team
- *Required: 3 involuntary admissions in last 2 years; meets certification criteria, services available, capable of complying, community treatment plan*
- *6 months, renewable; return to hospital if not complying.*

MENTAL HEALTH
Care & Treatment Act

Certification process (s. 16-25)

- Requires separate assessments, by two clinicians, verifying that the individual meets the criteria for involuntary admission. (*First and second certificates)*
- Physicians and nurse practitioners may sign the first certificate. Psychiatrist completes second certificate
- Police apprehend (s.20)-take to first certificate clinician
- Judge (s.19) can order person to be examined by first certificate clinician
- Inform the individual and his/her patient representative why the person has been certified and provide both with a copy of the certificate
- Notify rights advisor

MENTAL HEALTH
Care & Treatment Act

CERTIFICATION PROCESS

- Inform patient of rights
- Determine who Patient Representative is.
- Inform Patient Representative of detention/admission
- Provide patient with Rights Card
- Complete Psychiatric assessment & write notes on page 2 of Certificate of Involuntary Admission
- Ensure Certificate of Involuntary Admission is completed correctly
- Complete required parts of Involuntary Certification / Communication Checklist
- Ensure documents accompany patient upon transfer to another facility:
- Copy of Certificate of Involuntary Admission
- Checklist
- Police written Statement form (if RCMP are involved)

MENTAL HEALTH
Care & Treatment Act

CERTIFICATION PROCESS

Labrador Grenfell Health

- ✓ Inform patient of rights
- ✓ Determine who Patient Representative is
- ✓ Inform Patient Representative of detention/admission
- ✓ Provide patient with Rights Card
- ✓ Complete Psychiatric assessment & write notes on page 2 of Certificate of Involuntary Admission
- ✓ Ensure Certificate of Involuntary Admission is completed correctly
- ✓ Complete required parts of Involuntary Certification / Communication Checklist
- ✓ Ensure documents accompany patient upon transfer to another facility:
  - ➢ Copy of Certificate of Involuntary Admission
  - ➢ Communication Checklist
  - ➢ Police written Statement form (if RCMP/RNC are involved)

Reminder! Summary of Documentation Required:

- ➢ 5 copies of Certificate of Involuntary Admission
  One each for: patient, patient representative, medical chart, the administrator and the original to accompany patient to a Psychiatric Unit
- ➢ 4 Copies of Police Written Statement Form
  One each for: patient, patient representative, medical chart and the original to accompany patient to a Psychiatric Unit
- ➢ 3 copies of Communication Checklist
  One each for: medical chart, the administrator and the original to accompany patient to Psychiatric Unit

Copies of Certifications to be sent to the Administrator:

Sandy Penney
Regional Director, Mental Health & Addictions
Labrador West Health Centre
1700 Nichols-Adam Highway
Labrador City, NL A2V 0B2
Tel. (709)285-8221 Fax (709)944-9194
e-mail: sandy.penney@lghealth.ca

Reminder!
Summary of Documentation Required

- 5 copies of Certificate of Involuntary Admission
  One each for: patient, patient representative, medical chart, the administrator and the original to accompany patient to a Psychiatric Unit
- 4 Copies of Police Written Statement Form
  One each for: patient, patient representative, medical chart and the original to accompany patient to a Psychiatric Unit
- 3 copies of Communication Checklist
  One each for: medical chart, the administrator and the original to accompany patient to Psychiatric Unit

MENTAL HEALTH
Care & Treatment Act

Required Forms

- Certificate of Involuntary Admission
- Involuntary Certification / Communication Checklist

MENTAL HEALTH
Care & Treatment Act

Newfoundland Labrador

Department of Health & Community Services
Mental Health Care and Treatment Act
Section 17(1)

PLEASE PRINT LEGIBLY

COPY: ☐Original ☐Patient ☐Patient Representative ☐Administrator

First Certificate of Involuntary Admission

I, the undersigned physician/nurse practitioner_____, hereby certify that
(please print name)
at_____, at _____ time, on the _____day of
(please print address) *(am/pm)*
_____ month and _____ year, I personally conducted a psychiatric assessment of:

Name of person: _____
Address: _____
MCP Number:
(if applicable) _____

I hereby certify that I have made careful inquiry into all the facts necessary for me to form an opinion as to the nature of the named person's mental condition. As a result of this assessment, I am of the opinion that _____ (1) has a mental disorder[1]
(please print person's name)
and (2) as a result of that 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/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.

My opinion is based on:[2]

[1] "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 (MHCTA, 2006, s. 2 (1) (k)).

[2] The facts observed by the physician/nurse practitioner must be distinguished from those that have been communicated by another person. Additional information may be attached (MHCTA, 2006, s. 17 (1) (c)).

_____ 

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Signature of Physician/Nurse Practitioner *Time* *Date*

Second Certificate of Involuntary Admission

Date/Time of Arrival at the Second Facility: _____

I, the undersigned psychiatrist[3] _____, hereby certify that
(please print name)

at _____, at _____ time, on the _____day of
(please print address) *(am/pm)*

_____ month and _____ year, I personally conducted a psychiatric assessment of:

Name of person: _____
Address: _____
MCP Number:
(if applicable) _____

I hereby certify that I have made careful inquiry into all the facts necessary for me to form an opinion as to the nature of the named person's mental condition. As a result of this assessment, I am of the opinion that _____(1)
(please print person's name)

has a mental disorder[4] and (2) as a result of that
mental disorder:

_____

[3] The Act permits a physician to sign the second certificate where a psychiatrist is not readily available (MHCTA, 2006 Sec. 17 (2) b).

(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/her need for treatment or care and supervision; and,

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

The following facts[5] and reasons for my opinion above are as follows:

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Signature of Physician *Time* *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.

[4] "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 (MHCTA, 2006, s. 2 (1) (k)).

[5] The facts observed by the physician must be distinguished from those that have been communicated by another person. Additional information may be attached (MHCTA, 2006, s. 17 (1) (c)).

MENTAL HEALTH
Care & Treatment Act

Newfoundland
Labrador

PLEASE INITIAL IN SPACES PROVIDED AND SIGN ATTACHED SIGNATURE KEY

Involuntary Certification / Communications Checklist

Copy: Original _____

Person Arrived at Facility: Date: _____ Time: _____ Facility: _____
(mm / dd / yy)

Interpreter Required: ☐ Yes ☐ No

First Certificate (Section 22.1)

Date/time on certificate: Date: _____ Time: _____
(mm / dd / yy)

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

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

Communication Accountabilities (Patient)

Person has been verbally advised (Sections 11(1)(a), 12(4)(c), 14(1)(2)):

_____ Where s(he) has been detained

_____ Purpose of detention

_____ Right to retain / instruct counsel without delay

_____ Right to meet with rights advisor

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: _____

Person has been given (Sections 11(1)(b) & 12(4)(b)(d)):	**Patient refused:**
_____ Copy of certificate of detention, order or authorization	_____
_____ Information pamphlets	_____
_____ Rights as an involuntary patient	_____
_____ Mental Health Care and Treatment Review Board	_____
_____ Patient representative & rights advisor	_____
_____ What you should know	_____

Copy of certification papers placed on health record: _____

Communication Accountabilities (Patient Representative)

Patient representative advised (Sections 11(2)(a), 12(7), & 35(3)):

_____ Detention of person for the purpose of an involuntary psychiatric assessment

_____ Person's right to detain / instruct counsel without delay

_____ Person's admission / detention as an involuntary patient and reason

_____ Person's right to apply to the Review Board

_____ Right of the patient representative to meet with rights advisor

_____ Right to copies of all notices and other information given to the person

_____ Right to consult with the person's psychiatrist and represent views on diagnostic procedures, treatment, or alternatives

_____ Transfer of person to other facility

Initial in spaces provided and sign the attached signature key.

Mental Health Care and Treatment Review Board (Section 70)

Completed Review Board application faxed to 729-4429 (Section 66): _____

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Notification of Review Board hearing received: _____

Date of hearing: _____
(mm / dd / yy)

Copy of hearing notification provided to:

Patient: _____ Patient Representative: _____ Administrator: _____ Social Worker: _____

Notification to Review Board Chair (fax 729-4429) when person is either:

De-certified: _____ or application withdrawn: _____

Notification to rights advisor if:

Application withdrawn: _____

If a certificate has been overturned:

_____ Advised of right to leave hospital

_____ Returned to place of origin or other: _____

_____ Agreeable to stay: voluntary consent for treatment / admission signed

Initial in spaces provided and sign the attached signature key.

Second Certificate (Section 22.1)

Date/time on certificate: Date: _____ Time: _____
(mm / dd / yy)

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

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

_____

Notification of rights advisor (1-888-546-1222): Date: _____ Time: _____
(mm / dd / yy)

Communication Accountabilities (Patient)

Person has been verbally advised (Sections 11(1)(a), 12(4)(c), 14(1)(2)):

_____ Right to detain / instruct counsel without delay

_____ Reason for admission / detention as an involuntary patient

_____ Right to apply to the Review Board

_____ Right of the patient representative to meet with rights advisor

_____ Right to copies of all notices and other information given to the person

_____ Right to consult with their psychiatrist and represent views on diagnostic procedures, treatment or alternatives

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: _____

Person has been given (Sections 11(1)(b) & 12(4)(b)(d)): **Patient refused:**

_____ Copy of certificate of detention, order or authorization _____

Copy of certification papers placed on Health Record _____

Initial in spaces provided and sign the attached signature key.

Communication Accountabilities (Patient Representative)

Patient representative advised (Sections 11(2)(a), 12(7), & 35(3)):

_____ Person's right to detain / instruct counsel without delay

_____ Person's admission / detention as an involuntary patient and reason

_____ Person's right to apply to the Review Board

_____ Right of the patient representative to meet with rights advisor

_____ Right to copies of all notices and other information given to the person

_____ Right to consult with the person's psychiatrist and represent views on diagnostic procedures, treatment, or alternatives

Mental Health Care and Treatment Review Board (Section 70)

Completed Review Board application faxed to 729-4429 (Section 66): _____

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Notification of Review Board hearing received: _____

Date of hearing: _____
(mm / dd / yy)

Copy of hearing notification provided to:

Patient: _____ Patient Representative: _____ Administrator: _____ Social Worker: _____

Notification to Review Board Chair (fax 729-4429) when person is either:

De-certified: _____ or application withdrawn: _____

Notification to rights advisor if:

Application withdrawn: _____

If a certificate has been overturned:

_____ Advised of right to leave hospital

Returned to place of origin: _____ or other: _____

_____ Agreeable to stay: voluntary consent for treatment / admission signed

Initial in spaces provided and sign the attached signature key.

Renewals (Sections 30 & 31)

First Renewal

Renewal due date: _____
(mm / dd / yy)

Psychiatrist notified psychiatric assessment is required within 72 hours: _____

Date/time of renewal: Date: _____ Time: _____
(mm / dd / yy)

First renewal expires 30 days after signing of the first certificate

Copy provided to:

Patient: _____ Patient Representative: _____ Administrator: _____

Original certification paper on health record: ☐ Yes ☐ No

Original renewal papers on health record: ☐ Yes ☐ No

Patient refused copy of renewal papers: _____ Copy placed on health record: _____

Notification of rights advisor: Date: _____ Time: _____
(mm / dd / yy)

Second Renewal

Renewal due date: _____
(mm / dd / yy)

Psychiatrist notified psychiatric assessment is required within 72 hours: _____

Date/time of renewal: Date: _____ Time: _____
(mm / dd / yy)

Second renewal expires 60 days after signing of the second renewal

Copy provided to:

Patient: _____ Patient Representative: _____ Administrator: _____

Original certification paper on health record: ☐ Yes ☐ No

Original renewal papers on health record: ☐ Yes ☐ No

Patient refused copy of renewal papers: _____ Copy placed on health record: _____

Notification of rights advisor: Date: _____ Time: _____
(mm / dd / yy)

Initial in spaces provided and sign the attached signature key.

Automatic Review by Mental Health Care and Treatment Review Board (Section 33(1))

Completed Review Board application faxed to 729-4429: _____

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Notification to rights advisor: _____

Notification of Review Board hearing received: _____

Date of hearing: _____
(mm / dd / yy)

Copy of notification of hearing provided to:

Patient: _____ Patient Representative: _____ Administrator: _____ Social Worker: _____

Notification to Review Board Chair (fax 729-4429) when person is either:

De-certified: _____ or application withdrawn: _____

Notification to rights advisor if application withdrawn: _____

Third Renewal

Renewal due date: _____
(mm / dd / yy)

Psychiatrist notified that psychiatric assessment required within 72 hours: _____

Date / time of renewal: Date: _____ Time: _____
(mm / dd / yy)

Third renewal expires 90 days after signing of the third renewal

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Original certification paper on health record: ☐ Yes ☐ No

Original renewal papers on health record: ☐ Yes ☐ No

Patient refused copy of renewal papers: _____ Copy placed on health record: _____

Notification to rights advisor: Date: _____ Time: _____
(mm / dd / yy)

Initial in spaces provided and sign the attached signature key.

Fourth Renewal

Renewal due date: _____
(mm / dd / yy)

Psychiatrist notified that psychiatric assessment required within 72 hours: _____

Date / time of renewal: Date: _____ Time: _____
(mm / dd / yy)

Fourth renewal expires 90 days after signing of the fourth renewal

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Original certification paper on health record: ☐ Yes ☐ No

Original renewal papers on health record: ☐ Yes ☐ No

Patient refused copy of renewal papers: _____ Copy placed on health record: _____

Notification to rights advisor: Date: _____ Time: _____
(mm / dd / yy)

Automatic Review by Mental Health Care and Treatment Review Board (Section 33(1))

Completed Review Board application faxed to 729-4429: _____

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Notification to rights advisor: _____

Notification of Review Board hearing received: _____

Date of hearing: _____
(mm / dd / yy)

Copy of notification of hearing provided to:

Patient: _____ Patient Representative: _____ Administrator: _____ Social Worker: _____

Notification to Review Board Chair (fax 729-4429) when person is either:

De-certified: _____ or application withdrawn: _____

Notification to rights advisor if application withdrawn: _____

Initial in spaces provided and sign the attached signature key.

Fifth Renewal

Renewal due date: _____
(mm / dd / yy)

Psychiatrist notified that psychiatric assessment required within 72 hours: _____

Date / time of renewal: Date: _____ Time: _____
(mm / dd / yy)

Fifth renewal expires 90 days after signing of the fifth renewal

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Original certification paper on health record: ☐ Yes ☐ No

Original renewal papers on health record: ☐ Yes ☐ No

Patient refused copy of renewal papers: _____ Copy placed on health record: _____

Notification to rights advisor: Date: _____ Time: _____
(mm / dd / yy)

Sixth Renewal

Renewal due date: _____
(mm / dd / yy)

Psychiatrist notified that psychiatric assessment required within 72 hours: _____

Date / time of renewal: Date: _____ Time: _____
(mm / dd / yy)

Sixth renewal expires 90 days after signing of the sixth renewal

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Original certification paper on health record: ☐ Yes ☐ No

Original renewal papers on health record: ☐ Yes ☐ No

Patient refused copy of renewal papers: _____ Copy placed on health record: _____

Notification to rights advisor: Date: _____ Time: _____
(mm / dd / yy)

Initial in spaces provided and sign the attached signature key.

Automatic Review by Mental Health Care and Treatment Review Board (Section 33(1))

Completed Review Board application faxed to 729-4429: _____

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Notification to rights advisor: _____

Notification of Review Board hearing received: _____

Date of hearing: _____
(mm / dd / yy)

Copy of notification of hearing provided to:

Patient: _____ Patient Representative: _____ Administrator: _____ Social Worker: _____

Notification to Review Board Chair (fax 729-4429) when person is either:

De-certified: _____ or application withdrawn: _____

Notification to rights advisor if application withdrawn: _____

Decertification (Section 15(1)(c) & 32))

Decertification: Date: _____ Time: _____
(mm / dd / yy)

Notification to:

Patient: _____ Patient Representative: _____ Rights Advisor: _____ Review Board Chair: _____

Admission to hospital consent signed: ☐ Yes ☐ No

Patient discharged: _____

Hospital arrangements made for return of the person: ☐ Yes ☐ No

If yes, location: _____

Note:
Ensure there are no pre-existing orders, such as Criminal Code Detention, which would Continue after the person's status is voluntary.

Initial in spaces provided and sign the attached signature key.

Apprehension and Conveyance (Section 38(1)(a&b)

Patient Elopement

Completion of MHCTA Form #06 – Order for Apprehension and Conveyance of an Involuntary Patient Due to Unauthorized Leave

Date: _____ Time: _____
(mm / dd / yy)

Notification to: Patient Representative: _____ Administrator: _____ Police: _____

Failure to Comply With CTO (Sections 51(2)(b&c) & 51(3)(a&b)

Completion of MCHTA Form #08 – Order for Apprehension, Conveyance, and Examination of a Person Who Failed to Comply to Community Treatment Order

Date: _____ Time: _____
(mm / dd / yy)

Notification to: Patient Representative: _____ Administrator: _____ Police: _____

Transfers

Facility to Psychiatric Unit (Sections 75(1&3) & 77)

Date: _____ Time: _____
(mm / dd / yy)

Original Authorization to Transfer to Another Psychiatric Unit form on health record: ☐ Yes ☐ No

Notification to: Patient: _____ Patient Representative: _____ Rights Advisor: _____

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Communication accountabilities to patient and patient representative completed as noted under First Certificate:

☐ Yes ☐ No

Initial in spaces provided and sign the attached signature key.

Psychiatric Unit to Psychiatric Unit (Sections 75(1&3) & 77)

Date: _____ Time: _____
(mm / dd / yy)

Original Authorization to Transfer to Another Psychiatric Unit form on health record: ☐ Yes ☐ No

Notification to: Patient: _____ Patient Representative: _____ Rights Advisor: _____

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Communication accountabilities to patient and patient representative completed as noted under First Certificate:

☐ Yes ☐ No

Temporary Removal or Transfer to Another Facility (Sections 76(1&2) & 77)

Date: _____ Time: _____
(mm / dd / yy)

Original Authorization to Transfer to Another Psychiatric Unit form on health record: ☐ Yes ☐ No

Notification to: Patient: _____ Patient Representative: _____ Rights Advisor: _____

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Communication accountabilities to patient and patient representative completed as noted under First Certificate:

☐ Yes ☐ No

To Another Jurisdiction – Out of Province (Sections 81(1)(a) & 77)

Date: _____ Time: _____
(mm / dd / yy)

Original Authorization to Transfer to Another Jurisdiction form on health record: ☐ Yes ☐ No

Notification to: Patient: _____ Patient Representative: _____ Rights Advisor: _____

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Initial in spaces provided and sign the attached signature key.

From Another Jurisdiction – Into Province (Sections 81(3)(a, b) & 77)

Date: _____ Time: _____
(mm / dd / yy)

Original Authorization to Transfer into the Province form on health record: ☐ Yes ☐ No

Notification to: Patient: _____ Patient Representative: _____ Rights Advisor: _____

Copy provided to: Patient: _____ Patient Representative: _____ Administrator: _____

Note:
Upon arrival into the province, the patient will be detained and assessed in a psychiatric unit for an involuntary psychiatric assessment not to exceed 72 hours. Two psychiatric assessments are required to determine certification.

Initial in spaces provided and sign the attached signature key.

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

Initial in spaces provided and sign the attached signature key

Documentation

...

MENTAL HEALTH

Care & Treatment Act

MHCTA Branding

- Any information related to the Act and its implementation at the regional level will be identified by this wordmark.
- This wordmark, along with using the blue and green colours for covers and binders etc, will help identify the forms and materials you will use in your daily work.
- The leaf represents a new beginning for mental health services.

MENTAL HEALTH

Care & Treatment Act

The Act

- Paper copy given to all staff
- Electronic copy available on-line

MENTAL HEALTH

Care & Treatment Act

The Policy Manual

- Paper copy available in all regions
- Electronic copy available
- Covers policy and practice
- Includes the required forms for procedures (certification, transport etc)

Information Cards & Signage

- Rights cards for patient/patient representative
- Large print poster for psychiatric unit and public areas

Fact Sheets

- Mental Health Care and Treatment Act
- MHCT Review Board
- Patient Representatives and Rights Advisors
- Community Treatment Orders

MENTAL HEALTH
Care & Treatment Act

Forms

- Available electronically through government website and RHA websites
- Common “look” to aid quick recognition

MHCTA Website

- Fact Sheets
- Policy Manual
- Forms
- Web Links

MENTAL HEALTH

Care & Treatment Act

For more information:

- For more information, please visit your organization's website or government's at:

www.gov.nl.ca/health/mhcta

MENTAL HEALTH

Care & Treatment Act

For more information:

- Contact your local Mental Health Department or a Mental Health Case Manager in your area.
- There are 3 Mental Health Case Managers in our region located at the following sites:
    1) Flower's Cove
    2) Goose Bay
    3) Labrador City

MENTAL HEALTH
Care & Treatment Act