Guide to the Alberta Mental Health Act and Community Treatment Order Legislation
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The guide will be available online at the Alberta Health Services (AHS) website: www.albertahealthservices.ca/MHA.asp

Guide Updates
Please refer to the AHS, Addiction and Mental Health website for any changes and/or revisions of a significant nature to the Guide to the Alberta Mental Health Act and Community Treatment Order Legislation.

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Additional Sources of Information
Mental Health Act and regulations
The Act and regulations can be viewed at the Government of Alberta, Health and Wellness, Health Legislation website: www.health.alberta.ca/about/health-legislation.html or is available for purchase from:

Queen’s Printer Bookstore
Main Floor, Park Plaza
10611 – 98 Avenue
Edmonton, AB T5K 1P7
Phone: (790) 427-4952
Website: www.qp.alberta.ca

Mental Health Act forms
Electronic versions of all the Mental Health Act forms are available on the Alberta Health Services website at: www.albertahealthservices.ca/1256.asp. These forms can be a) completed on the computer and then printed and signed, or b) printed then completed by hand and signed. They may not be altered in any way.

The Alberta Mental Health Act: Guide for Mental Health Service Users and Caregivers
This guide and related documents were produced by the Canadian Mental Health Association, Calgary Region and are available online at: www.cmha.calgary.ab.ca/mentalhealth/mentalhealthact.aspx
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Limits of the guide

This guide has been written as a resource for healthcare professionals, service providers in mental health and related agencies, advocacy organizations, peace officers and other interested parties.

The purpose of the guide is to simplify and summarize key themes and provisions in the Mental Health Act and its regulations, and recent amendments. Other relevant legislation (e.g. the Adult Guardianship and Trustee Act, the Health Information Act, and the Public Inquiries Act) are noted. Readers are encouraged to view the legislation directly.

This document is intended as a guide and as general information only, and is not to replace the advice of a lawyer. Examples herein are for illustrative purposes and should not be viewed as authoritative statements of the law. Readers should consult a lawyer if in need of legal advice or clarification regarding the application of the Act. Further, this guide is not intended to replace or supersede regional health authorities’ (or other) internal policies.

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Questions and answers

A series of questions and answers, found at the end of chapters two through nine, address practice issues relevant to both community and hospital settings. Questions related to community treatment orders are preliminary as these were implemented in January 2010.

Judge-made law (common law) and legislation continually change over time. This guide reflects the Mental Health Act and its regulations as well as the legal setting of designated facilities as of January 1, 2010.

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Alberta Health Services invites your comments and suggestions for enhancing the contents of this document.

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Introduction

The Alberta Mental Health Act

One in three people will have a mental health problem in their lifetime. This significant health and quality of life issue crosses all demographic, cultural and socio-economic barriers. A recent study over a three-year period found that “35% of adult Albertans consulted a physician and were given a mental disorder diagnosis”. The number of people treated in the community was far greater than those treated by specialists. Those with the most serious diagnosis (e.g. psychosis) were more likely to be seen by psychiatrists. (1)

Some individuals with the most serious and persistent mental disorders may refuse to access help or not recognize the need for psychiatric treatment. Refusal to accept care can cause pain and disruption which may lead to harm for those individuals, their families and the community. In order to protect and treat those individuals with serious mental disorders and to protect the public, legislation has been put in place.

History of Mental Health Legislation in Alberta (2) (3)

Earliest legislation in Alberta was concerned with the safety of society. In 1879 a justice of the peace could incarcerate those deemed dangerous to be at large, insane and most likely to be associated with a criminal offence. A jail was the only available detention centre. By the late 1880s the criteria of dangerousness and suspected criminality were set aside; a person could be confined to jail or other safe custody for reasons of insanity alone.

Although the concept of ‘dangerous to be at large’ returned in the Insanity Act of 1907, important next steps were reflected in the requirement that a qualified medical practitioner provide evidence before a person could be confined. Additionally, there was a provision that a judge of the Supreme Court of Alberta could review any committal.

The Insanity Act was renamed the Mental Diseases Act in the 1924. Asylums were now called hospitals and it was recognized that hospitalized individuals were sick and required care and treatment. In 1942 the word insane was replaced by mentally diseased.

In 1964 all those with a mental disorder came under the same legislation. The first Mental Health Act of Alberta proposed a community centered approach to mental health care. Decisions to admit individuals to hospital were made by physicians and time limits to the length of detention were identified. Equally important was the formation of independent review panels.

With the 1989 Mental Health Act patient rights were aligned with those in the Canadian Charter of Rights and Freedoms. The provision of care and treatment for formal patients expanded from provincial psychiatric hospitals to a further 15 designated facilities in towns and cities across the province. Forensic psychiatry services and facilities were provided in both Edmonton and Calgary. Since that time, amendments to the Act have related to treatment issues.

Footnotes:


2) Hashman, K., and Hoffner, C. (No year given). Presentation to First Year Residents.

Current Mental Health Legislation

The most recent amendments of the Mental Health Act, proclaimed in two stages on September 30, 2009 and January 1, 2010, followed a lengthy process of consultation and review. These amendments are threefold: 1) to broaden the criteria for certification to permit earlier intervention and treatment, 2) to send known family physicians a discharge summary and recommendations for treatment upon the discharge of a patient from a facility, and 3) to introduce community treatment orders (CTOs) to encourage individuals to maintain mental health treatment in the community and ideally reduce the need for hospitalization.

The Act provides the authority, criteria, procedures and timelines for the apprehension, detention, admission and treatment of an individual as a formal patient and contains other provisions that apply to all patients who fall under the Act. Finally, the Act identifies separate criteria and conditions for supportive treatment of persons living in the community – including some who are former formal patients. Adults, seniors and minors may be admitted as formal patients or subject to a CTO if they meet the criteria outlined in the Act.

Further to the above amendments, the role of Alberta’s Mental Health Patient Advocate has been expanded. Previously, the Advocate could intervene only if a person had formal patient status, that is, had two admission or two renewal certificates. The Advocate’s office is now also able to respond to and investigate complaints when a person is detained under one certificate. Their jurisdiction also extends to persons subject to CTOs.

Protection of Individual Rights within the Mental Health Act

Whether an individual is involuntarily admitted or issued a CTO, the Act protects his/her rights by identifying what those rights are and directing that they are made known to the individual - and others who may advocate for them - in a timely manner.

Safeguards for patients include, for example, the right to know why they are being detained, to notify others about their detention and to apply to a review panel to review or cancel certificates and CTOs. Patient rights also incorporate visits from legal counsel and appeal of review panel decisions to Court of Queen’s Bench. The Act provides patients who are subject to one or two admission or renewal certificates or a CTO, and those acting on their behalf, with the legislated right to contact the Mental Health Patient Advocate for rights information, support and to investigate concerns or a complaint.

Protection of patient rights goes hand in hand with treating the person respectfully and as an individual. Care and treatment not only provide safety in times of crisis but reflect ongoing compassion for the patient and his/her circumstances. Finally, healthcare professionals and mental health service providers involve the patient in treatment planning, offering support for recovery and hope for the future.

Guide to the Alberta Mental Health Act and Community Treatment Order Legislation

The guide is divided into chapters that reflect the primary areas dealt with in the Act and regulations:

- the authority and mechanisms to apprehend and convey for examination (Chapter 2),
- criteria for admission and detention as a formal, involuntary patient (Chapter 3),
- a formal patient’s rights while detained in a designated facility, including to apply for review of decisions about their detention and treatment (Chapter 4),
- the function of review panels to respond to applications (Chapter 5),
- determining a person’s capacity to make treatment decisions, and appointing another individual to Act on their behalf if the person lacks capacity (Chapter 6),
• provisions for persons who are subject to community treatment orders, effective January 1, 2010 (Chapter 7),
• confidentiality and access to health information (Chapter 8), and
• the appointment, powers and duties of the Mental Health Patient Advocate (Chapter 9).

The meaning of “the board” in the Act

In this guide, there are citations from the Act which reference “the board” (e.g. section 14(1)(b)). When the Act imposes a duty on or grants a power to the “board”, in practice this has likely been delegated to an Alberta Health Services employee or physician within the facility, depending on the circumstances. Readers of the guide are encouraged to check with management in the facility to determine to whom a particular responsibility or power has been delegated.

The use of “regional health authority”

Readers will note the use of “regional health authority” throughout the guide. At the time the guide is written, there is only one regional health authority – Alberta Health Services. The Mental Health Act, however, does not reflect the consolidation of numerous health authorities into a single health authority. The legislation simply refers to “regional health authorities” and is interpreted in accordance with whatever ministerial orders (reorganizing health authorities) are in place at the time of interpretation. We have taken a similar approach in this guide.
Designated Facilities

This chapter will cover

- what are designated facilities,
- how formal and voluntary patients are admitted to designated facilities,
- how minors are admitted to designated facilities,
- how forensic patients are admitted to designated facilities, and
- how to lodge complaints with designated facilities.
1.1 Introduction to Designated Facilities

Meaning of “designated facilities”

Designated facilities are “places (or parts thereof) that have been designated in the Mental Health Regulations as ‘facilities’ for the purpose of the Mental Health Act.” In practice, the term “designated facilities” refers to inpatient health facilities which have been authorized by the Lieutenant Governor in Council as the only hospitals which can admit and detain formal or involuntary patients under the Mental Health Act. There are many hospitals in Alberta but only a limited number are designated facilities. A list of designated facilities as of October 2010 is in Appendix III (section 1(1) of the Mental Health Regulation 19/2004).

1.2 Voluntary Patients in Designated Facilities

Designated facilities may admit patients who are not formal or involuntary patients but who present for mental health assessment and voluntarily accept admission and psychiatric treatment. This is often the case in urban centres where the acute care hospitals offering psychiatric care are designated facilities.

Many people admitted to hospital for psychiatric care and treatment have sought help of their own volition. For example, individuals or family members may make an appointment with a family physician or psychiatrist when ‘something is wrong’. Alternatively, they may have accessed help at a community clinic or a local emergency department (ER).

In the course of the assessment interview with the physician and healthcare team, the individual and/or family member relates changes in the way he/she is functioning, thinking, feeling or behaving. The person recognizes the need for help and is willing to accept it. The team assesses safety issues and the availability of support, as well as the person’s ability to understand and carry out treatment suggestions.

Depending upon the severity of the symptoms and the amount of support available in the family and community, the person might be admitted to hospital voluntarily, discharged from ER for follow-up treatment in the community, and/or continue seeing his/her family physician or psychiatrist. If admitted voluntarily, the person would be able to discharge him/herself at any time – with or without a physician’s advice.

1.3 Formal Patients in Designated Facilities

A person becomes a formal patient when admitted involuntarily and detained in a designated facility by the issuing of two admission or renewal certificates. Physicians take seriously the decision to revoke individual freedoms and certify a person with a mental disorder who is otherwise not willing to accept admission or treatment. They are guided by the Mental Health Act which contains the criteria that must be met in order to detain a person involuntarily in a designated facility. The Act further identifies the rights of the formal patient.

1.4 Minors in Designated Facilities

The Mental Health Act makes no age distinctions. In Alberta, a minor - anyone under the age of 18 years, as well as adults may be admitted as formal patients when they meet the three criteria for admission under the Act.

However, minors may also be admitted as voluntary patients, usually with the consent of their parents or guardians or pursuant to the authority of legislation (for example, The Child, Youth and Family Enhancement Act).
1.5 Forensic Patients in Designated Facilities

When a person is remanded to custody for observation or detained for treatment under the *Criminal Code* (Canada) or the *Youth Criminal Justice Act* (Canada) that person is admitted to one of the two designated facilities in Alberta authorized to admit these individuals for examination, treatment, detention and discharge in accordance with the law (section 13 of the *Act*, and section 1(2) of the Mental Health Regulation) (see Appendix III).

1.6 Complaints about Designated Facilities

Complaints about designated facilities should be addressed with a member of the treatment team so those caring for the patient are aware that a concern or problem exists. This can result in a timely response to the need, for example providing additional or clarifying information, support, or corrective action. Patients, their agents, guardians, and/or families can also take complaints and suggestions to the facility administration or Patient Concerns Department. In addition, patients under one or two admission or renewal certificates, or those acting on their behalf, have access to the Mental Health Patient Advocate for information, support or investigation of complaints.

As well, the Office of the Ombudsman, the Protection for Persons in Care Office, and the Health Facilities Review Committee are able to conduct investigations concerning designated facilities (see Appendix V).
Apprehension and Conveyance to a Designated Facility; Detention in a Designated Facility

This chapter will cover

- how to access a physician’s examination under the Act,
- why there is a provision for apprehending and conveying an individual,
- how a Provincial Court judge, peace officer and physician facilitate apprehension and conveyance of a person, including someone not complying with a CTO, to a designated facility,
- what criteria is necessary for any person, adult or minor to be made a formal patient,
- what timeframes are allowed for conveyance and apprehension,
- what timeframes are allowed for physician’s examination and detention under one admission certificate at the designated facility,
- what rights an individual has when one admission certificate is issued, and
- questions related to apprehension, conveyance and detention in practice.
2.1 Apprehension, Conveyance and Detention

These terms are used in the Act to describe the process of seeking out and taking a person to a designated facility for examination by a physician. The person is detained (kept at the facility) for the time allowed under the Act to conduct the examination.

This could happen, for example, when a person with an apparent mental disorder exhibits severe and worsening symptoms and behavioral changes. The individual is apparently unconcerned or unwilling to accept help when it is offered by family, friends or healthcare workers. It is possible under the Act to have the person taken to a designated facility for examination by a physician.

Common methods of apprehension and conveyance

This section will focus on the three most common routes that lead to a person being brought to a designated facility for examination to determine whether he/she meets the criteria to be admitted as a formal patient.

The authority to apprehend an apparently mentally disordered person can be given by the following people:

- a physician using Form 1: Admission Certificate (section 2 of the Act),
- a Provincial Court judge using Form 8: Warrant (section 10 of the Act), or
- a peace officer using Form 10: Statement of Peace Officer on Apprehension (section 12 of the Act).

Other methods of apprehension and conveyance

A person may also be conveyed to a designated facility under the authority of

- Form 23: Community Treatment Order Apprehension Order (section 9.6 of the Act),
- Form 4: Certificate of Transfer into Alberta (section 24(1) of the Act),
- an admission certificate issued under section 3 of the Act for a person detained under the Criminal Code (Canada) or the Youth Criminal Justice Act (Canada) who has been found
  - unfit to stand trial, not criminally responsible because of their mental disorder, or not guilty by reason of insanity, and
  - the person’s detention is about to expire.

2.2 Apprehension and Conveyance by First Admission Certificate

The initial assessment may occur in the community (e.g. family physician’s office) where the physician determines whether the person meets the criteria necessary for issuing a Form 1: Admission Certificate under the Act. The completion of one admission certificate allows time and provides the legal authority for the individual to be brought, if not by family or friends, then by a peace officer to a designated facility for further examination.

If the admission certificate is completed in the ER of a designated facility, the Act permits the person to be detained for a specific limited time in order that activities prescribed under the Act may take place.

The person detained by one certificate is advised that he/she is being held under the Act, for how long, and must be given contact information for the Mental Health Patient Advocate.
Three criteria for admission certificate

In order to complete a Form 1: Admission Certificate the examining physician must believe that a person is

• suffering from a mental disorder,
• likely to cause harm to that person or others, or to suffer substantial mental or physical deterioration or serious physical impairment, and
• unsuitable for admission to a facility other than as a formal patient (section 2 of the Act).

All three criteria must be met.

Definition of “mental disorder”

“Mental disorder” means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs

• judgment,
• behavior,
• capacity to recognize reality, or
• ability to meet the ordinary demands of life (section 1(g) of the Act).

The meaning of the third criterion

“Unsuitable for admission to a facility other than as a formal patient” may mean that

• there are concerns that the patient would leave hospital abruptly and come to harm, e.g. be at higher risk for suicide, if admitted voluntarily, or
• the person being examined may be considered to lack the mental capacity to understand and consent to admission and treatment.

Further, this third criterion may be met

• when a competent person - or an incompetent person’s agent, guardian or substitute decision-maker (SDM) – refuses to consent to that individual being admitted to a facility to receive psychiatric treatment.

Note: it may be appropriate to make a complaint under section 75 of the Adult Guardianship and Trusteeship Act if the SDM is not acting in the best interest of the person.

2.3 Timeframes for Examination by a Physician; First Admission Certificate

A physician in the community or a hospital may issue a Form 1: Admission Certificate within 24 hours of examining a person (section 2 of the Act).

If a Form 1 certificate has been issued in the community, any person (frequently a peace officer) is allowed 72 hours from the time the Form 1 is issued to apprehend the person named in the certificate and to care for, observe, assess, detain, control and convey him/her to a designated facility (section 4 of the Act).

When a person is detained in a facility under a Form 1 certificate, or a person is conveyed to a facility (under section 10, 12 or 24 of the Act) the detained person must be examined as soon as possible by a physician who is on staff at the receiving facility (section 5(1) of the Act). The examining physician at the receiving facility does not have to be a psychiatrist.
When assessing the patient’s mental state, collateral information from family and friends, community healthcare workers, peace officers and members of the community is taken into account.

Options following issuance of the first admission certificate

At the designated facility, the second physician (i.e. the physician who did not issue the first admission certificate) who separately assesses the detained person may issue a second admission certificate.

If a second admission certificate is not signed within 24 hours of the person’s arrival at the designated facility, the person can no longer be detained involuntarily and shall be released (section 5 of the Act).

Alternatively in practice, at the expiration of the first certificate with the competent person’s consent, the physician may treat the person as a voluntary patient. If the incompetent person’s substitute decision-maker consents, the physician may also continue to treat the person.

2.4 Warrant for Apprehension Issued by a Provincial Judge (Forms 7 & 8)

When a person will not see a physician

Help can be accessed through the Provincial Court by families, caregivers, healthcare workers and peace officers. This could be an option, for instance, when a person with a mental disorder stops taking prescribed medication, appears unable to care for him/herself, is having a recurrence of severe symptoms yet refuses to see a physician.

Section 10 of the Act allows any individual, including a peace officer, to bring information under oath before a Provincial Court judge by filling out Form 7:Information. The closest provincial courthouse can provide direction as to where to go and how to bring a Form 7 before a judge. The process varies in each geographic area.

Criteria to be met

The individual bringing the information to the judge must believe that the person referred to in the information is

- suffering from a mental disorder, and
- likely to cause harm to that person or others, or
- to suffer substantial mental or physical deterioration or serious physical impairment (section 10(1) of the Act).

Information to relate to a judge

It is necessary for the individual bringing information to the judge to describe the incident(s) and behavior(s) of the person that are causing concern. Healthcare workers, and indeed families, may bring notes to which they can refer. As well as completing documents, the individual bringing the Form 7 to the judge should expect to answer questions and discuss with the judge information related to the individual’s previous episodes of mental illness, diagnosis and current medications.

The judge must be satisfied that the above criteria have been met, and that a mental health examination cannot be arranged in any other way. The judge may then issue a Form 8: Warrant. This warrant provides authority for the peace officer to apprehend the person named in the warrant, to care for, observe, assess, detain and control while conveying him/her to a facility for examination.
2.5 Extension of the Warrant (Form 9)

The warrant expires 7 days after it is issued by the Provincial Court judge, unless it is extended under section 11 of the Mental Health Act for a further 7 days. Such an extension is available only once.

A peace officer may make the application to extend the warrant.

- This may be done by telephone or other means of telecommunication if it is impracticable for the peace officer to appear personally before the Provincial Court judge.
- The information on which the application is based must be given under oath and recorded verbatim.
- The information must include a statement of the circumstances that make it impracticable for the peace officer to appear personally before the provincial judge.
- The order and a transcript of the information must be filed with the clerk of the court.

2.6 Apprehension by a Peace Officer (Form 10)

In the course of their work peace officers encounter people with mental illness - many of whom are not a danger to others or themselves. Peace officers become involved when they observe behaviors that are of concern, when they receive requests for assistance from family or healthcare workers, or complaints from a member of the community. They intervene under the Act when they are satisfied that the person is apparently a person with a mental disorder and acting in a manner likely to cause harm to self or others, or to suffer substantial mental or physical deterioration, or serious physical impairment.

Criteria for apprehension using a Form 10: Statement of Peace Officer on Apprehension

Section 12 of the Act provides that a peace officer may apprehend and convey a person to a facility for examination when they have reasonable and probable grounds to believe that a person

- is suffering from a mental disorder, and
- is likely to cause harm to the person or others, or to suffer substantial mental or physical deterioration, or serious physical impairment, and
- should be examined in the interests of the person’s own safety or the safety of others.

The peace officer must also believe that to delay apprehending an individual by first bringing information under oath before a Provincial Court judge is dangerous (e.g. when apparent injuries or extreme behaviors of the individual may justify immediate apprehension and conveyance to a hospital).

The peace officer may then apprehend the person and, while conveying him/her to a facility for examination, can care for, observe, assess, detain and control the person.

When the peace officer conveys the person to a facility, the peace officer must complete a statement using Form 10. Required information includes the name of the individual (if known), the date, time and place at which the person was apprehended, and the grounds (relative to the Act) upon which the person was apprehended.
2.7 Apprehension and Conveyance of a Person not Complying with a CTO

There are three processes whereby a peace officer may apprehend and convey a person not complying with a CTO.

1. By carrying out a judge's warrant (Form 8)
   - Issued when someone brings information under oath before a judge about a person subject to a CTO regarding the informant’s reasonable and probable grounds to believe the named person is not complying with their CTO.
   - The warrant gives peace officers the authority to apprehend and convey the named individual to a facility for examination (section 10(5) of the Act).

2. By carrying out a CTO apprehension order (Form 23)
   - Completed and signed by a psychiatrist or designated physician who has reasonable grounds to believe the person subject to a CTO has failed to comply with the CTO.
   - Form 23 gives a peace officer authority to apprehend (including the entering of premises) and convey a person named in that order (sections 9.6(1) of the Act).

3. By acting pursuant to section 12(1) of the Act under peace officer discretion (Form 10)
   - In this process, in order to apprehend and convey, the officer must have reasonable and probable grounds to believe that
     - a person is suffering from a mental disorder and
     - is subject to a CTO and is not complying with the CTO, and
     - the person should be examined in the interests of the person’s own safety or the safety of others, and
     - the circumstances are such that to proceed under section 10 would be dangerous.
2.8 Questions about Apprehension, Conveyance and Detention in Practice

1. **What is the definition of a “peace officer” in relation to the *Mental Health Act***?

   Although the *Mental Health Act* does not define “peace officer”, the *Police Act* and *Peace Officer Act* do. The Ministry responsible for both the acts is the Alberta Solicitor General and Ministry of Public Security.

   All police officers in the Province of Alberta may make apprehensions under the *Mental Health Act* but only some peace officers are permitted these responsibilities. Section 7 of the *Peace Officer Act* provides that the Solicitor General and Minister of Public Security can appoint a person as a peace officer to hold broad or limited authorities, dependant on job functions.

   Therefore, only certain peace officers are authorized to do apprehensions under the *Mental Health Act*. Examples include:

   1) all Alberta police officers (most commonly accessed by healthcare workers and the public),
   2) sheriffs who protect government infrastructure (e.g. courts, legislature grounds),
   3) conservation officers,
   4) fish and wildlife officers, and
   5) peace officers who work in hospitals (note: not all security personnel in hospitals are peace officers).

2. **Is it legally permissible for a physician to examine an individual by way of videoconferencing in order to issue the first admission certificate under the Act?**

   The *Act* is silent, and we are unaware, at the time of drafting this guide, of Canadian court cases addressing this issue. However, legal literature has suggested that these examinations via interactive videoconferencing would be legal so long as the legislative requirements are met. Some other countries have endorsed videoconferencing for this examination. (The CTO regulation explicitly permits examination by way of video conference for the purpose of CTOs.)

   Psychiatrists may wish to consult with their professional college, legal counsel, and/or the Alberta Medical Association for advice prior to conducting such examinations by videoconference. In practice in Alberta, such examinations have occurred and have not been challenged.

3. **Can a person under one admission certificate contact the Mental Health Patient Advocate (the Advocate)?**

   Yes. The Patient Advocate Regulation has been amended so that the Advocate is legislated to investigate complaints and provide rights advice to patients who are or have been subject to one or two admission certificates as well as those subject to a CTO, or to those acting on the patient’s behalf.
4. **Can an admission certificate be issued for a person who is intoxicated or impaired by drugs or alcohol?**

Yes. When a physician believes the person he/she has examined meets all three criteria necessary for the issuance of an admission certificate, the physician can complete a first admission certificate and advise the person that he/she is being detained for up to **24 hours** from time of arrival.

For example, disorientation, confusion, safety concerns, lack of judgment or insight and reluctance to accept help are only some of the concerns with an individual who is acutely intoxicated or impaired which may make him/her unsuitable for care except under the Act. Sometimes the individual's mentally disordered state clears before a second certificate is issued (in which case the patient may be discharged or remain as a voluntary patient).

5. **Is a peace officer required to complete a Form 10 when he/she brings a person believed non-compliant with a CTO to hospital for examination under the authority of a Form 23 or Form 8?**

No; duplicate forms are not required. Any one of these three processes by itself - whether Form 8: Warrant (section 10(1.1)), or Form 23: Community Treatment Order Apprehension Order (section 9.6(1)), or Form 10: Statement of Peace Officer on Apprehension (pursuant to section 12(1)) - gives authority to apprehend and convey a person subject to a CTO and believed non-compliant with a CTO to a facility for examination.

6. **Is the peace officer required to leave the Form 10 at the facility?**

Yes. The Form 10 is completed and signed by the peace officer at the designated facility and the original of the copies is left with admitting/triage personnel for inclusion in the person's health record (section 12(3) of the Act).

7. **Why is it important for Emergency Department staff to note the time of arrival of any patient coming in under a Form 1: Admission Certificate, Form 8: Warrant, Form 9: Extension of Warrant or Form 10: Statement of Peace Officer on Apprehension?**

Staff must document the time of arrival at the facility in order that the physicians (whether in ER or an inpatient unit) can work in compliance with the timeframes provided in the Act. The **24 hour** time-frame allowed for examination and completion of admission certificate(s) is determined from the time of the person’s arrival at the designated facility (section 5 of the Act).

8. **Are individuals with Fetal Alcohol Spectrum Disorders or Pervasive Developmental Disorders, eligible for admission as a formal patient?**

Yes; the specific diagnosis is not the issue. If a person meets all three criteria for certification under the Act he/she may be admitted as a formal patient.
Admission and Detention

This chapter will cover

- how to admit and detain a person as a formal patient using two admission certificates,
- what information is required on an admission certificate,
- how the detention period is extended by issuing renewal certificates,
- how to remand a person to a designated facility for examination,
- how the formal patient can apply for cancellation of admission and renewal certificates,
- how formal patients may be granted a leave of absence while hospitalized,
- how formal patients are transferred between designated facilities,
- when a patient is discharged from a designated facility,
- questions about admission and detention in practice,
- Flowchart and Key Points: Formal Patient Certification.
3.1 Second Admission Certificate

If a person is brought to a facility under a peace officer’s power (Form 10) or a judge’s warrant for apprehension (Form 8), two physicians must examine and complete two admission certificates within 24 hours of time of the patient’s arrival at the facility in order for the person to be detained as a formal patient (section 5(2) of the Act).

If brought to a facility under one admission certificate (Form 1), a second admission certificate must be signed within 24 hours of the person’s arrival at the designated facility or the person must be released on the expiry of 24 hours (section 5(3) of the Act).

In practice, a person may be admitted to an inpatient unit from ER with one admission certificate, but, in order for the person to be detained as a formal patient, a second admission certificate must be issued in the timelines stated above.

These two admission certificates are sufficient authority to diagnose, care for, observe, assess, treat, detain and control the person in a facility for 1 month after the admission certificate is issued (section 7 of the Act).

Refusal of admission to a facility

If a person is conveyed to a facility under one admission certificate and a second admission certificate is not issued, the board must inform the patient, and (if the patient does not object) also inform the referring source - the physician who issued the first admission certificate - of the reasons why a second certificate was not issued. The person may be referred to another facility or service, and if so, this information should also be provided to the referral source (section 18(1) of the Act).

Responsibility for informing the issuer of the first admission certificate that the person was not certified

Section 18 gives this responsibility to the board; however, in clinical practice this responsibility has been delegated to facility staff or physicians. The physician will be most aware of the reasons for not issuing a second certificate and certifying a patient. It may be appropriate that the second physician communicate with the physician who issued the first certificate. Other necessary information to impart includes any arrangements or recommendations made for follow-up care.

3.2 Contents of Admission Certificates

*Mental Health Act* certificates are legal documents. It is essential that they be legible and accessible to the patient and those acting on their behalf. Both admission certificates must include the

- name of the person,
- name and address of the physician signing the admission certificate,
- date and time when the physician’s examination was conducted,
- facts leading to the physician’s opinion that the person is
  - suffering from a mental disorder, and
  - likely to cause harm to that person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and
- unsuitable for admission to a facility other than as a formal patient.
• name of facility where the person was examined, or if not in a facility, the name and address of the facility to which the person is to be conveyed to be examined,

• date and time the certificate was issued,

• signature and printed names of the physicians.

3.3 Extending the Detention Period by Renewal Certificates

If a formal patient requires hospitalization beyond the period of 1 month from the date the second admission certificate was issued, there is a mechanism under the Act to extend the period of detention.

It requires two physicians, one of whom must be a psychiatrist and the other a member of the facility’s staff, to separately examine the formal patient before the expiry date of the second admission certificate. When the patient meets the criteria for certification the physicians may extend the term of detention by each issuing a renewal certificate within 24 hours after their examination using Form 2 (section 8(1) of the Act).

Criteria for renewal certificates

The two physicians must separately believe that the formal patient is

• suffering from a mental disorder, and

• likely to cause harm to that person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and

• unsuitable to continue at the facility other than as a formal patient.

Section 8(3) provides for use of renewal certificates (Form 2) to extend the period of detention

• in the first instance of renewal, for 1 month,

• in the second instance, a further month,

• in the third and subsequent instances, 6 additional months.

The Act does not specify that the renewal certificates have to be completed within 24 hours of each other. In practice, both renewal certificates must be issued before the date and time of expiry of the second certificate (sections 7 and 8 of the Act).

3.4 Completion of Forms

Section 52 provides that all forms issued under the Act, including those that are required in order to admit and detain a person (e.g. admission certificates, renewal certificates, warrants, orders, and transfers), shall not be held to be insufficient or invalid by reason only of any irregularity, informality or insufficiency in the form or in any proceedings in connection with the form.

Missing information and corrective action

Certificates are legal documents; it is important that they are filled out completely and accurately. If information is missing on a certificate, or added after the certificate is signed, it is possible that the certificate will not be valid. That being said, it is also possible that the certificate is still valid pursuant to section 52 of the Act. Whether or not the certificate is valid depends on what information is missing or added in. Ultimately it is up to a review panel (or, on appeal, a Court) to determine the certificate’s validity. Healthcare providers may address specific questions to their organization’s internal legal services.
3.5 Admission and Detention Arising from an Arrest for Criminal Charges

When a person with a mental disorder is arrested on a criminal charge, one or more of the following actions may occur:

- a person can be discharged outright or released on bail, or
- a person capable of consenting to treatment can be treated voluntarily in a remand centre, while awaiting court proceedings,
- depending upon the nature of the criminal charges, the person may be released on bail, with the requirement to participate in outpatient mental health services,
- an examining physician may believe that the person meets the requirements to be involuntarily detained in a designated facility, and may sign a first admission certificate. The person will then be conveyed to a designated facility, where he/she will be assessed by another physician for his/her eligibility relative to a second admission certificate,
- depending on the nature of the criminal charges, the Crown Prosecutor may redirect the person to the Provincial Diversion Program,
- a court can order the person to be conveyed to a designated forensic facility for assessment regarding whether the person is fit to stand trial. During the assessment period, the person can be treated voluntarily or be detained under the Mental Health Act as an involuntary patient,
- a court can order that a person be detained in a facility and order involuntary treatment to enable the person to become fit to stand trial.

A person serving a sentence in a provincial correctional centre (less than 2 years incarceration) or a federal penitentiary (2 years or more incarceration) may be transferred to a designated forensic facility.

- An assessment will be conducted, and the person may be returned to the place where he/she was originally incarcerated.
- Alternatively, the person may be admitted involuntarily pursuant to admission and renewal certificates and serve the remainder of his/her sentence in a designated forensic facility.

A person found by a court to be Not Criminally Responsible due to a Mental Disorder (NCRMD) will be sent to a forensic psychiatric unit until they are released by the Alberta Review Board.

3.6 Application to Cancel Certification and Detention

Under the 1982 Constitution Act in Canada, a person has the right to a hearing to review his/her detention (Part I: Canadian Charter of Rights and Freedoms). Similarly, the Mental Health Act is explicit about the right of the formal patient to apply for a hearing to review his/her detention and consider cancellation of admission or renewal certificates issued by the two physicians. For this reason, review panels accept applications from anyone who is detained under the Act.

Three types of review panel applications related to admission and detention

- A formal patient, the patient’s agent, the patient’s guardian or a person acting on the patient’s behalf may apply to a review panel to cancel admission certificates or renewal certificates (section 38), using Form 12.
- An automatic review of a formal patient’s admission or renewal certificates occurs at or after 6 months if no review has been held earlier (section 39 of the Act).
• A patient may apply to a review panel to be transferred back to a correctional centre (section 33), using Form 12. If the person is a formal patient, the review panel will first need to decide whether to cancel the admission or renewal certificates.

3.7 Leave of Absence

During hospitalization formal patients may be allowed to spend time outside the facility. A leave of absence
• permits formal patients to live temporarily in the community though they remain under the powers of the Act,
• may be granted based on terms and conditions, such as where patients will be staying and with whom, and
• requires that patients may still be subject to the supervision and treatment of any person(s) designated by the board (section 20(2)) of the Act.

Nothing in the Act specifies the length of time for which a leave may be granted; it may be revoked at any time.

A formal patient detained in or remanded to a facility under the Criminal Code (Canada) or the Youth Criminal Justice Act (Canada) (formerly the Young Offenders Act) is not eligible for a leave of absence (section 20(5) of the Act).

Leave of absence decisions and arrangements

The formal patient may request leave or it may be suggested by the family or treatment team when a reason arises: such as being with the family for a special occasion dinner, cleaning his/her apartment or, looking for employment or a place to live. In practice, a physician writes an order for the leave of absence from hospital after discussion with the patient, treatment team, guardian, relevant family or, supportive community members.

The purpose of the leave is usually therapeutic and also gives an opportunity to assess the patient’s functioning outside of hospital. The length of the leave, medication to be taken and who will be responsible for the patient should be identified. The patient and supervising person, if any, must understand the medication routine and be aware of the parameters of the leave.

Initial leaves of absence (sometimes called passes), may be quite brief. In the course of the individual’s hospitalization the duration of leaves may increase as patient improvement and readiness for discharge approaches.

Absence without leave

Should a formal patient on a leave of absence refuse or neglect to return to a facility, the facility may declare the patient “absent without leave” and may order a peace officer to return the patient to the facility by completing Form 3: Order to Return a Formal Patient to a Facility (section 20(4) of the Act).

If a formal patient leaves a facility when a leave of absence has not been granted, the facility may use Form 3 to order a peace officer to return the patient to the facility (section 21(1) of the Act). Form 3 gives peace officers the authority to apprehend and return the patient to the facility (section 21(2) of the Act).
Information to give a peace officer about the patient named in Form 3

Peace officers are aided by knowing the physical description of the named individual, any characteristic mannerisms and identifying marks. They should also be told when the patient was last seen, what clothes the person was wearing when last seen and what, if any, risks the patient poses to self and others when away from the facility.

Staff should notify peace officers if the patient returns voluntarily or is otherwise brought back to the facility so peace officers are aware they need not continue looking for the person named in the Form 3.

3.8 Transfers

There are times when a formal patient may need to be transferred to another healthcare centre, for example, when required treatment is provided elsewhere or because he/she lives in another province and is being taken to a facility closer to home. Each situation is outlined in the Act and requires the use of appropriate forms and the transfer of Mental Health Act certificates in effect at the time.

Formal patients may be transferred

• to another designated facility using Form 6 (section 22 of the Act),
• to a hospital for treatment, and then returned to the facility (section 23 of the Act),
• from outside the province to an Alberta facility using Form 4 - provided that the requirements for an admission certificate are met (section 24(1) of the Act),
• to a facility outside Alberta if another jurisdiction is responsible for the patient’s care and treatment, or it is in the patient’s best interests to be cared for in another jurisdiction, using Form 5 (section 25 of the Act).

(For information on signing authority for Forms 4, 5 and 6 see Chapter 3.10, question 5, in the guide.)

3.9 Discharge

Discharge of a formal patient is most often associated with the end of certification and detention. There are a number of reasons why certificates may cease to be in effect (section 31 of the Act).

• When a formal patient no longer meets the certification criteria, the physician must cancel the admission or renewal certificates.
• When a formal patient’s admission or renewal certificates are cancelled or expire, the patient must be informed that he/she remains in the facility voluntarily.
  • The patient may continue with mental health treatment as a voluntary inpatient, or if inpatient treatment is not appropriate, the patient may be discharged.
  • The patient may also be discharged against medical advice.
• When a review panel finds that the patient no longer meets the criteria for admission certificates or renewal certificates, the patient is informed of the cancellation of certificates and may elect to be discharged or continue as a voluntary patient.
Notice of discharge

Upon discharge of voluntary patients (including those patients receiving treatment with consent of a substitute decision-maker) and formal patients, notification must be provided to the patients and, where reasonably possible, his/her

- guardian, if any,
- nearest relative, unless the patient objects,
- family doctor, if known (including a discharge summary and recommendations for treatment).

When applicable in the notice of discharge it must be stated whether the person has a certificate of incapacity under the Public Trustee Act (section 32(1) of the Act).

Patients eligible for transfer or discharge who refuse or fail to leave the facility are legally trespassers. Arrangements may be made to transfer such a patient to another area in the facility, to an approved hospital, or to a nursing home or other accommodation (section 32(3) and section 32(2) of the Act).
1. **Two admission certificates are sufficient authority to detain a person “for a period of 1 month from the date the second admission certificate is issued.” What is “1 month”?**

   Section 22(8) of the Interpretation Act answers this question.

   “22(8) If an enactment contains a reference to a period of time consisting of a number of months after or before a specified day, the number of months shall be counted from, but not so as to include, the month in which the specified day falls, and the period shall be reckoned as being limited by and including

   (a) the day immediately after or before the specified day, according as the period follows or precedes the specified day, and

   (b) the day in the last month so counted having the same calendar number as the specified day, but if that last month has no day with the same calendar number, then the last day of that month.”

   For example, if a second certificate is issued January 5, the patient may be lawfully detained until the end of the day February 5.

   Because section 22(8)(b) can be confusing, caution should be taken (and legal advice sought if necessary) when calculating the detention period when a certificate is issued near the end of a month when the next month has fewer days (e.g. when a second certificate is issued on January 30, but February only has 28 days, the patient may be lawfully detained until the end of the day on February 28.)

2. **Does the Act give direction regarding the content requirements of the physician discharge summary and the timeframe within which this must occur?**

   Section 32 of the Act states that discharge notices to family physicians are to include a discharge summary, any recommendations for treatment and, if applicable, state whether a certificate of incapacity, under the Public Trustee Act, exists for that patient. (This includes certificates formerly issued under the Dependent Adults Act that were transferred to the Public Trustee Act in October of 2009.)

   The intent of the discharge summary is to keep the family doctor apprised of sufficient information and advice about the patient so effective follow-up treatment can be provided.

   There are no specifics noted and no time frame stipulated in the Act. To be of value, the notification should be done in a timely fashion, or in other words, within a reasonable time under the circumstances.

3. **If a formal patient is being transferred from one designated facility to another within the same AHS zone or city, is it necessary to complete and send Form 6?**

   Yes. Section 22(1) of the Act and Form 6 relate to the transfer from one facility to another; AHS zoning is irrelevant.
4. When a formal patient with a substitute decision-maker (“SDM”) is transferred to another designated facility is it necessary to obtain a new consent to treatment from the substitute decision-maker or is the SDMs original consent (as obtained by the referring facility) still valid?

The Act does not speak to this. Healthcare providers should follow the consent policy applicable to their facility. Generally speaking, it may be good practice to obtain a new consent since consent to treatment is usually specific as to who is providing treatment. Further, if any new treatment is to be provided, new consent should be obtained.

5. What signatures are required on Forms 4, 5 and 6?

Form 4: Certificate of Transfer into Alberta and Form 5: Transfer of Formal Patient to a Jurisdiction Outside Alberta require the signature of the Minister of Health and Wellness or designate.

In Ministerial Order #53/99, the Minister delegated his powers under sections 24 and 25 of the Mental Health Act to “the person who occupies the position of the senior official in charge of patient services at each facility listed in the attached Appendix [which lists mental health facilities designated in the Mental Health Regulation] with respect to the formal patients transferred in and out of the facility at which the person holds the position.”

Form 6: Memorandum of Transfer to Another Facility requires the signature of the representative of the board of the sending facility.

Healthcare providers requiring information or confirmation of names of those with appropriate signing authority should contact a senior administrative person in their service (e.g. Director or Executive Director for Addictions and Mental Health Services).

6. Can Protection or Security Services in ER access the patient’s mental health forms (e.g. admission certificates) to confirm the “validity” of the certificate(s) and or their role in detaining the patient if required?

Traditionally, the role of security services has not included reading certificates to verify information documented by clinicians. In practice, it is the responsibility of the treatment team to supply accurate, timely, “need-to-know” information that security services require in order to perform their duties when the situation warrants their involvement. Such information might include a patient’s certification status, possible elopement risk, or risk of harm to self or others. With this information the security team can minimize and manage risks to self, the patient, staff and the public in the performance of their role. Security personnel can rely on the information given to them by healthcare professionals (such as the fact that a patient is certified) without checking the certificates.

Notwithstanding the above, regardless of whether protection services/security services are facility/regional health authority employees or contracted to provide services, they are “affiliates” under the Health Information Act. Therefore, they can access and use patient’s health information in a manner consistent with their duties to the facility/regional health authority. However, the Health Information Act mandates that they should only access and use the minimum amount of health information necessary to carry out their purpose.

7. What mechanism is used to record cancellation of certificates?

The Act provides no specific direction about how to cancel certificates. Many physicians write the order “cancel certificates” on the treatment record with the date and their signature. Some physicians also write “cancelled” with the date and their signature on the actual certificate in the health record. Documentation of the reasons for the cancellation of the certificates is good practice.
8. Can a formal patient be charged with a criminal offence that allegedly occurred while they had formal status?

Yes. All persons in designated facilities, including formal patients, are subject to the Criminal Code of Canada. Should an alleged offense be committed by a formal patient while in a facility (e.g. the assault of another patient or a staff member), healthcare providers (or others) can notify their local police service to lodge a complaint.

9. In the event a formal patient is charged under the Criminal Code for an offence that allegedly occurred while the patient had formal status, should in-house legal counsel be notified?

Yes. For example, currently all formal patients are at AHS facilities; thus AHS legal services should be notified.

10. When a formal inpatient is charged with a criminal offense that allegedly occurred while they had formal status, where will they be detained?

Where a formal inpatient will be detained depends upon the nature of the charge. For instance, if a formal patient is charged with a non-detainable offense (a criminal offense that the criminal justice system deems most appropriately dealt with by a Notice to Appear in Court), the person receives a Notice to Appear in Court and remains an inpatient under the care of the clinical team at the designated facility. (In practice, the patient may be transferred to a unit other than the one where the offense occurred.)

In a circumstance where the formal patient has assaulted someone on an inpatient unit of a designated facility and is charged with a detainable offense (a criminal offense that the criminal justice system deems suitable to result in incarceration), the person may not be released by the judge pending trial but, since a formal patient cannot be incarcerated in a remand facility or jail, must be returned to the designated facility. In such a situation the attending physician may be of the opinion that the person is unsuitable for continued care at the facility where the offense occurred. The physician may give his/her written opinion and request of the judge (if the Court has not already ordered it), that the formal patient be moved to a designated forensic facility or unit for treatment in a more secure setting.

The formal patient's transfer is authorized by the Court and coordinated by the police and the treatment teams at both designated facilities. All current Mental Health Act certificates (or copies thereof, depending on the facility's policy) and required legal papers such as the Detention Order must accompany the formal patient to the designated forensic facility. Local policies/procedures developed for such a contingency will facilitate the transfer of care of the formal patient from a designated facility to a forensic designated facility.

11. Is a formal patient's mental health certificate still valid when a facility has a photocopy of the certificate instead of an original or a carbon copy?

The certificate is still valid. However, the original certificate may be required by a review panel or Court during a hearing.

For the review panel, legibility of the certificate is a primary concern. In order to provide a fair hearing the panel must be able to read the reasons for the issuance of any certificate. As examples

- “reasons for my opinion” are written by physician(s) on a certificate of mental incompetence to make treatment decisions,
- “the facts observed by me” and “facts communicated to me by others” provide physicians' reasons for a patient's detention under admission/renewal certificates, and
- “the facts on which I formed the above opinion” support the physician's issuance of a community treatment order.
12. Is an original signature required on all Mental Health Act forms?

An original signature is required on each Mental Health Act form that is deemed appropriate to the situation. When copies are distributed, and no clear carbon copies are available, best practice is to have original signatures on the other “copies” of the original forms. If, instead, a copy is given to the recipient (e.g. receiving facility) with a photocopied signature, the form is still valid; however as stated in question 11 the form with an original signature may be required by a review panel or Court during a hearing. Without an original signature, there can be practical problems and/or evidentiary problems during the hearing.
3.11 Flowchart and Key Points: Formal Patient Certification
A. Definition of Mental Disorder
(see MHA 1(9))
A substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life.

B. Apprehension by Warrant or Peace Officers Statement (see MHA 10 and 12)
To apprehend a person to conduct an examination, the Judge and/or the Peace Officer must have reasonable and probable grounds to believe that the person is in a condition likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment and:
Judges Warrant: (section 10, Form 8)
- There is no other way to arrange for an examination.
- Application supported by sworn information that the person is suffering from mental disorder.
Peace Officer: (section 12, Form 10)
- The person is suffering from a mental disorder.
- The person should be examined for their own safety or the safety of others.
- Circumstances are such that proceeding under section 10 would be dangerous.

C. Three Criteria for Formal Patient Certification (see MHA 2(a-c))
- Suffering from a mental disorder
- In a condition likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment
- Unsuitable for admission to a facility other than as a formal patient

D. Admission Certificates

Effect of One Admission Certificate (see MHA 4(1))
Gives sufficient authority to:
- Care for, observe, assess, detain and control, apprehend and convey to a facility within 72 hours of issue.
- Care for, observe, assess, detain and control the person during apprehension and conveyance.
- Care for, examine, assess, treat, detain and control the person for up to a maximum of 24 hours after arrival at facility unless a 2nd certificate is written.

Effect of Two Admission Certificates (see MHA 7(1,2))
Gives sufficient authority to:
- Care for, observe, examine, assess, treat, detain and control the person named on the certificate for up to one month after issuing of the certificate.
- One certificate must be signed by a physician on staff at the facility.
- If needed, Renewal Certificates must be completed prior to expiry of existing certificates.

E. Informing Patient and Others (see MHA 14)
Who*
- Patient
- Patient’s agent, substitute decision maker (SDM)
- Patient’s nearest relative (unless patient objects)
- Patient may designate one person s. 14 (1) & (4)

What
- The reason for issuance of the certificates.
- The authority for detention and the period of it.
- Function of the review panel.
- Notice of the right to apply for a review panel hearing to appeal treatment orders, certificates or finding of incompetence.

F. Documentation
- Patient’s and Others’ receipt of:
  - Certificates
  - Verbal and written information about formal status: reasons, duration and legal rights, date completed.
- Patient’s awareness and apparent understanding of formal status and legal rights.
- Response to information, behavior & mental status.
- If an appeal is being made.
- Patient’s consent or refusal of treatment.
- Not documented = Not done.

G. Review Panel (see MHA 34-43)
- Composed of a chair or vice-chair (must be a lawyer), a psychiatrist, a physician, a member of the general public (see MHA 34-36). Review panel members may not be on staff at the facility and must not be treating or have treated the patient.
- The applicant and the applicant’s representative have a right to be present during presentation of evidence.
- Use Form 12 to apply for review panel hearing.
- A board (usually delegated to a physician) may apply on behalf of form a formal patient (MHA 38(2)).
- A board or attending physician may apply to review panel for treatment order (MHA 29 (2)).
- Any decision or order of the review panel may be appealed to the Court of Queen’s Bench.

H. Control (see MHA 30)
Control is the minimal use of reasonable force, by mechanical means or medication - without patient’s consent – as necessary to prevent serious bodily harm to the person or another person.
If interventions / medications, are used to control the behavior, not to treat patient, staff must document behavior requiring control and measures used.

I. Mental Competency (see MHA 28)
Competency means that the person is able to understand the subject-matter relating to, and the consequences of, making treatment decisions or giving consent & the consequences of not doing so.

Additional Information
- Formal Patient Certificates (admission / renewal) are cancelled on the issuance of a Community Treatment Order. (MHA 9.1(3))
- On admission as a formal patient, the Community Treatment Order should be cancelled (MHA 9.6(4c))
- Mental Health Patient Advocate services available at any time.

## Form Name | Completed by
---|---
1 Admission Certificate | 2 Physicians
2 Renewal Certificate | 1 Physician 1 Psychiatrist
3 Order to Return a Formal Patient to a Facility | Board’s Delegate e.g. Physician
4 Certificate of Transfer into Alberta | Minister of Health and Wellness or designee
5 Transfer of Formal Patient to a Facility Outside Alberta | Minister of Health and Wellness or designee
6 Memorandum of Transfer to Another Facility | Board’s Delegate e.g. Physician, at sending facility
7 Information | Informant
8 Warrant | Judge
9 Extension of Warrant | Judge
10 Statement of Peace Officer on Apprehension | Peace Officer
11 Certificate of Incompetence to Make Treatment Decisions | A) Physician & B) Rep of Facility Board, usually a Physician
12 Application for Review Panel Hearing | Patient / SDM / Board / Anyone
13 Notice of Hearing Before Review Panel | Review Panel Chair
14 Decision of Review Panel Regarding Mental Incompetence to Make Treatment Decisions | Review Panel Chair
15 Decision of Review Panel Regarding Treatment | Review Panel Chair
16 Decision of Review Panel regarding Transfer back to a Correctional Facility | Review Panel Chair
17 Decision of Review Panel regarding Admission Certificates, Renewal Certificates or CTO | Review Panel Chair
18 Decision of Review Panel Regarding Renewal Certificates & CTO’s (Deemed Application) | Review Panel Chair

DISCLAIMER: This document is intended as a guide and should not be used as a legal reference or advice. Please consult a lawyer if in need of clarification or legal advice. The information herein is not fully comprehensive; for complete details please refer to Alberta's Mental Health Act and the accompanying regulations. AHS is not liable in any way for actions based on the use of information contained herein.

8/27/2010
This chapter will cover

- what rights are extended to adults and minors who are formal patients,
- how and when formal patients are notified of their rights,
- how formal patients can apply to the review panel to cancel their admission or renewal certificates,
- how the Mental Health Patient Advocate promotes and protects the rights of patients under one or two certificates,
- what rights are extended to both formal and voluntary patients,
- how formal patients have the right to consent to and refuse treatment (though the right may be limited in specified circumstances), and
- questions about formal and voluntary patients’ rights in practice.

In the Constitution Act, 1982, the Canadian Charter of Rights and Freedoms outlines a number of rights that are guaranteed to all, including the right to life, liberty and security of the person. Mental health legislation in Alberta and other Canadian provinces provides for involuntary detention and treatment in defined circumstances. The legislation creates a number of “checks and balances” to protect individuals, such as specialized review panels to hear applications relating to involuntary detention and treatment.
The meaning of “the board” in the Act

When the Mental Health Act imposes a duty on or grants a power to the “board”, in practice this is likely delegated to Alberta Health Services employees or physicians within the facility, depending on the circumstances. Readers are encouraged to check with management in the facility to determine to whom a particular responsibility or power has been delegated.

When formal patients are notified of their rights

When one admission certificate is issued, the individual named on the certificate is advised that he/she is being held under the Act and for how long. He/she must be given contact information for the Mental Health Patient Advocate. It is not until two admission or two renewal certificates are issued that a person is deemed a formal patient and can be detained involuntarily beyond 24 hours.

Formal patients are informed of their rights under the Act during their detention when

- two admission or renewal certificates are completed and a person is involuntarily detained,
- a patient’s status is changed from voluntary to formal,
- certificates are cancelled or expire – changing the patient’s status from involuntary (formal) to voluntary, and
- a formal patient is transferred from another designated facility.

4.1 Notification of Certification and Right to Appeal

When two admission or renewal certificates are issued, section 14 of the Act obliges the board of the facility to notify specific individuals of the certification and the reasons for certification. In clinical practice, this responsibility has been delegated to facility staff or physicians (e.g. reviewing the contents of the certificate with the individual at the time they give the patient his/her copy).

Simple language is used to inform:

1) the formal patient, 2) the patient’s guardian and, unless the patient objects, 3) the patient’s nearest relative, of the following

- the reason the admission certificates or renewal certificates were issued and,
- the patient’s right to apply to the review panel to cancel the admission or renewal certificates.

A written statement must be given to as many as four people:

1) the formal patient, 2) the patient’s guardian, 3) one person designated by the patient and, unless the patient objects, 4) the patient’s nearest relative.

In summary, this written information must include

- the reason, in simple language, for the issuance of the admission or renewal certificate,
- the authority for the patient’s detention, the length of the detention and copies of the admission or renewal certificates,
- the function of review panels,
the right to apply to the review panel for cancellation of the admission or renewal certificates, and

the name and address of the chair of the review panel assigned to the facility where the patient is located (section 14(1) of the Act).

In the event of language difficulty, a suitable interpreter is to be accessed who can provide the above information verbally and in writing in the language spoken by the formal patient or their guardian (section 14(2) of the Act).

If the patient has designated another person to receive notices, the facility is to mail a copy of all notices and information required to be given to the patient to the person at the address provided by the patient.

4.2 Notification of the Right to Communication, Visitors, Lawyers and the Mental Health Patient Advocate

All patients have the right to

• send and receive communications from outside the facility without the communications being opened, examined, delayed or withheld (section 15 of the Act),

• meet with visitors at approved times, unless a physician considers that a visitor would be detrimental to the patient’s health (section 16(1) of the Act),

• visits from a lawyer at any time (section 16(2) of the Act), and

• contact the Mental Health Patient Advocate (the Advocate) for information, advice or to lodge a complaint.

Note: The Advocate does not have the authority to receive complaints from or investigate complaints relating to voluntary patients under the Act.

4.3 Right to Treatment

On a patient’s admission, the board of a designated facility must provide the diagnostic and treatment services that the patient (whether formal or voluntary) is in need of and that the staff of the facility is capable of providing and able to provide (section 19(1) of the Act).

4.4 Right to Consent to or Refuse Treatment

Mentally competent patients generally have the right to consent to or refuse treatment with some very limited exceptions.

If a formal patient is not mentally competent, his/her agent, guardian, or nearest relative can consent or refuse to consent to treatment on the formal patient’s behalf (section 28 of the Act).

4.5 Control

Section 30 of the Act provides authority to control a person under the Act without the person’s consent to the extent necessary to prevent serious bodily harm to the person or to another person. Control is exercised by the minimal use of such force, mechanical means or medication as is reasonable with regard to the physical and mental condition of that person.

Staff and physicians have a responsibility to ensure safety for the patients in their care and also have the right to safety in their workplace.
It is important to remember that “control” is different than “treatment”. Patients have a right to refuse treatment (unless under a treatment order or a Form 11 with consent from a substitute decision-maker), but do not have a right to refuse to be controlled. This distinction may be discussed with patients. If interventions or medications are used to control behaviour, not treat the patient, staff must document the behaviour requiring control and the measures used.

4.6 Right of Formal Patients to a Second Opinion Regarding Competency to Make Treatment Decisions

In situations where an agent or nearest relative has made a treatment decision on behalf of an incompetent formal patient, and the incompetent formal patient objects to the treatment, a second opinion must be sought from a physician regarding the patient’s competency to consent to treatment. *(This does not apply when the patient’s guardian has made a treatment decision.)* Treatment cannot be given pursuant to the consent provided by the agent or nearest relative unless the second physician is also of the opinion that the patient is not mentally competent to make treatment decisions (section 28(5) of the *Act*).

4.7 Right of Formal Patients to Apply to Review Panels

A review panel is a group of four people who are specialized in knowledge and the application of the Mental Health Act. When a formal patient applies to the review panel a hearing is held. There is no cost to the formal patient for the hearing and the decision of the review panel is made known to the patient immediately or at the most, within 24 hours. *(Chapter 5 of the guide gives a full description of the application process, review panels and their functions.)*

Formal patients have the right to apply to a review panel and request that

- admission certificates or renewal certificates be cancelled (sections 14(1)(b), 38(1) and 41(1)(a) of the *Act*). The formal patient’s agent, guardian, or another person may make this application on the formal patient’s behalf, or

- the physician's certificate of incompetence to make treatment decisions be cancelled (sections 27(3) and 41(1)(b) of the *Act*).

The formal patient and his/her representative (e.g. the patient’s lawyer) have the right to be personally present during the presentation of any evidence, and to cross-examine any person who presents evidence. The only exception is when the review panel is of the opinion that disclosure of information to the patient might seriously endanger the safety of another person (section 37(4) of the *Act*).

4.8 Right to Appeal to Court of Queen’s Bench

If the patient is unsuccessful in challenging admission or renewal certificates or a certificate of incompetency before the review panel, the patient may appeal to the Court of Queen’s Bench. The appeal is a rehearing of the matter on the merits (section 43(4) of the *Act*). The waiting time for the Court’s decision is longer than that for a review panel hearing decision.
1. **What written information is staff obliged to give the formal patient?**

The Act stipulates that a written copy of the admission or renewal certificates (which includes the reason and authority for admission and detention and how long the detention lasts) must be given to the formal patient.

In addition, legislation requires that formal patients be given, in writing, the function of the review panel, the name and address of the review panel chair as well as a statement that the patient has a right to apply for cancellation of admission or renewal certificates.

It is good practice for clinicians to provide formal patients, guardians, agents, and nearest relatives with brochures on formal patients, review panels and Legal Aid. Additional written material on community treatment orders and the role of the review panel with CTOs are available for persons subject to a CTO and their advocates. Providing such brochures assists in meeting the written information requirements in the Act.

Treatment team members are also required to give information about the Mental Health Patient Advocate to every detained patient under one or two certificates as well as to a person subject to a community treatment order. This requirement is readily met by providing a copy of the Mental Health Patient Advocate brochure. Furthermore, a poster promoting the Mental Health Patient Advocate’s role in supporting patients under the Act is available for hospital emergency departments, inpatient units, and clinics as well as any areas where patients access mental health services.

2. **How can these brochures be ordered?**

A. The following brochures are available for downloading at the Government of Alberta, Health & Wellness website: www.health.alberta.ca/newsroom/pub-mental-health.html
   - **Formal Patients Under the Mental Health Act** – December 2009
   - **Review Panels Under the Mental Health Act** – December 2009
   - **Community Treatment Orders** – December 2009
   - **Review Panels: Community Treatment Orders** – December 2009

B. The Mental Health Patient Advocate provides both a brochure and poster which can be ordered by contacting: info@mpha.ab.ca
   - **View Brochure - You Have Rights Under the Mental Health Act** - Here to Help You
   - **View Poster - Here to Help You**

C. Legal Aid Alberta provides no cost brochures. Ask for the brochure titled
   - “Do you need affordable, professional legal assistance?”
   www.legalaid.ab.ca/resources/Pages/brochures.aspx#content

D. Mental Health Act forms, including Form 12: Application for Review Panel Hearing are available on the AHS website: www.albertahealthservices.ca/1256.asp
3. **How soon after two admission or renewal certificates are issued are formal patients to be notified of their certification and rights?**

It is recommended that formal patients be given such information promptly and without delay.

4. **Why is it important for the formal patient to be notified without delay of their certification and to receive information about the review panel?**

This is important because the person is being detained involuntarily. The Charter rights of individuals detained in Canada include the right to be notified promptly that they are being detained, the reasons they are being detained and how they can apply for a hearing to have their detention reviewed. Under the *Mental Health Act*, that review of detention takes the form of a review panel hearing.

5. **What if the patient does not understand his/her rights when he/she is notified of certification?**

At the time of admission many formal patients are so ill they are unable to comprehend the information provided. Some patients may have a language difficulty which will necessitate finding an interpreter.

Staff must document the time(s) they attempted to give notification and what circumstances, if any, prevented them from doing so. Documenting attempts to deliver verbal and written notification reflects the healthcare provider’s awareness of requirements under the *Act* and the patient’s rights. When formal patients have difficulty understanding or receiving their rights information due to the nature of their illness, staff should repeat their efforts to explain. Successive attempts should be documented. Staff taking over care of the patient can complete the notification process when the situation or patient’s condition permits. It is also good practice to document what information was given, and the patient’s reaction to, as well as, apparent level of understanding of the information.

Review panels, courts, the patient’s legal representatives and the Mental Health Patient Advocate may look for documentation as evidence that the patient was given rights information promptly, or if applicable, what prevented the patient from receiving complete information promptly.

Remember, section 14(1)(b) of the *Act* requires that information about the formal patient’s right to appeal to a review panel also be given to the formal patient’s guardian, if any, as well as one person designated by the patient and, unless the patient objects, their nearest relative. This helps ensure that others are aware of the patient’s rights and can advocate on their behalf if necessary.

6. **Do minor formal patients have the same rights as other formal patients?**

Yes. The *Act* makes no age-based distinctions.
Mental Health Review Panels

This chapter will cover

- who sits on a review panel and what is its purpose,
- who can apply: formal patients including minors, those considered not competent to make treatment decisions, formal patient’s representatives and physicians, or persons subject to a CTO,
- what applications are heard,
- how legal representatives can access health records,
- how independence and objectivity of review panels are safeguarded,
- how hearings are conducted,
- when review panels may refuse to hold a hearing,
- how review panel decisions can be appealed,
- how formal patients with a guardian under the Adult Guardianship and Trusteeship Act exercise their rights under the Act, and
- questions about the review panel and hearings in practice.
5.1 Purposes and Composition

Review panels are established to consider applications for a hearing from formal patients in designated facilities, from individuals subject to a community treatment order (“CTO”), and also from the board or attending physician of a formal patient. At the hearings the review panels determine whether a formal patient is competent, should continue to be detained involuntarily in the facility, and/or have treatment decisions made for them. Review panels also determine whether a person should remain subject to a CTO. Review panels are composed of four members: a chair or vice chair (who must be lawyers), a psychiatrist, a physician and a member of the general public (section 34(4) of the Act).

There are three review panels in Alberta:

- Calgary and South Mental Health Review Panel
  (covering AHS Zone 1: Southern Alberta, and AHS Zone 2: Calgary)

- Central Alberta Mental Health Review Panel
  (covering AHS Zone 3: Central Alberta) and;

- Edmonton and North Mental Health Review Panel
  (covering AHS Zone 4: Edmonton, and AHS Zone 5: Northern Alberta)

5.2 Types of Applications Heard by a Review Panel

Applications by formal patients, persons who are subject to CTOs or their representatives, can be made for the following reasons by completing Form 12: Application for Review Panel Hearing.

- to cancel admission certificates or renewal certificates (section 38(1) of the Act). The review panel will inform the applicant of a decision using Form 17.
- to cancel a CTO (section 38(1.1) of the Act). The review panel responds using Form 17.
- to ask for a review of a physician’s opinion that the formal patient is not mentally competent to make treatment decisions - Form 11 (section 27(3) of the Act). The review panel’s decision is noted on Form 14.
- to transfer a person back to a correctional centre (section 33 of the Act). This applies to persons who have been sent to a facility for psychiatric treatment, after being sentenced to a correctional facility. If the person is a formal patient, the review panel will first need to decide whether to cancel the admission or renewal certificates. The review panel’s decision is made on Form 16.

Applications to review panels from physicians

Physicians may also apply to a review panel (using Form 12) to order treatment (section 29 of the Act)

- where a mentally competent formal patient refuses to consent to treatment, or
- where an individual who has legal authority to make treatment decisions for an incompetent formal patient refuses consent to treatment.
The application process

The patient has the right to apply to a review panel, or another person (such as a relative, guardian or agent) may also apply on the patient’s behalf. When advised that the patient/representative intends to apply to a review panel, the Act directs the board to facilitate the submission of an application (section 14(3)).

In practice staff can, for example, answer questions about the patient’s right to apply to the review panel, provide the patient/representative with the application (Form 12), answer questions related to completing the form, confirm the name and address of the review panel chair and help the patient mail or fax the application to the review panel chair.

The review panel considers the application as soon as it is able to do so and in any case within 21 days of the chair receiving the application. Using Form 13, the review panel chair replies to the patient/representative applicant:

• giving 7 days written notice of the date, time and place of the hearing (e.g. the hearing is held in the facility where the patient is hospitalized), and
• advising of the right to contact Legal Aid and providing necessary contact information.

5.3 Safeguarding the Rights of the Patient Appearing before a Review Panel

Confidence that the hearing will be fair

The review panel works independently of the facility in which the person is detained. In addition, the Act contains safeguards to protect the review panel’s objectivity (section 36). These safeguards include preventing individuals who previously or currently have a professional or private relationship with the patient from participating as a review panel member.

These individuals are those who are

• related by blood or marriage or by virtue of an adult interdependent relationship,
• the patient’s spouse or adult interdependent partner,
• a psychiatrist, physician or other health services provider who is treating or who has treated the person appearing before the review panel, or
• a lawyer who is acting or who has acted on the patient’s behalf.

Staff of the facility are not permitted to sit as review panel members when the review panel is considering an application relating to a patient in that facility.

5.4 Conduct of Hearings

Members of the review panel have all of the powers, duties and immunities of a commissioner under the Public Inquiries Act (section 37(1) of the Act).

The review panel can

• summon any individuals as witnesses and require them to give evidence, and produce any documents, and
• enforce the attendance of individuals as witnesses and compel them to give evidence.

Review panel hearings are conducted in private; no person is allowed to attend a hearing without the permission of the review panel chair (section 37(2) of the Act).
The applicant (e.g. the formal patient or person subject to a CTO) and the applicant’s representative (e.g. the patient’s lawyer or agent) have the right to attend when evidence is presented, and cross-examine any individual who presents evidence (section 37(3) of the Act).

However, when the review panel is of the opinion that disclosure of information to the patient might seriously endanger the safety of another person, the review panel may refuse to disclose information to a patient (section 37(4) of the Act).

This is a description of review panel hearings from Legal Aid, Alberta, acting as the formal patient’s representative (duty counsel):

All hearings are structured in basically the same fashion. An introduction of the panel and an overview of the process are given to the patient. The hospital’s case is presented first, usually by the attending psychiatrist, and is not given under oath.

Evidence from the patient’s health record - nurses’ notes, medication notes as well as discussions with family and the patient which have been recorded in the chart - is accepted by the review panel. The panel may also cross-examine the psychiatrist.

At the conclusion of the psychiatrist’s evidence, duty counsel (and in some instances, the formal patient) has the opportunity to cross-examine. At the close of the hospital’s case duty counsel presents the patient’s case. Again the evidence is not under oath and the patient is subject to cross examination by the psychiatrist and the panel.

At the close of the patient’s case an opportunity is given for summation to each party and the panel retires to consider the matter and to make its decision. A written copy of the decision is given to the parties and written reasons follow. Copies of the reasons for the decision are not normally forwarded to duty counsel.

5.5 Refusal to Hold a Hearing

Review panels may refuse to consider applications for hearings in limited circumstances (section 38(4) of the Act). No further application shall be considered by the review panel if the chair reasonably believes

• the application is frivolous, vexatious or not made in good faith, or
• there has been no significant change in the circumstances of the formal patient or person subject to a CTO since the previous hearing.

5.6 Further Function of Review Panels – Review after 6 Months and Deemed Application for a Hearing

The Act provides for a periodic review of a formal patient’s detention, or a person’s CTO even if the individual has not applied for a hearing. As a result, a formal patient or a person subject to a CTO is deemed to have applied to the review panel if an application from the individual or representative has not been considered by the review panel within a set period of time.

Formal patients

Unless an application for review has been made (and not withdrawn or cancelled) within 6 continuous months of the admission certificates or renewal certificates being signed, the review panel will conduct a hearing as if the patient applied for it and consider cancellation of the admission or renewal certificates (section 39(1) of the Act). This is commonly referred to as a ‘6 month review’.
The person subject to a community treatment order

CTOs can be renewed for periods of 6 months and there is no limit on how many times the CTO may be renewed if the person continues to meet the criteria. The person who is subject to the CTO is deemed to have applied to the review panel for cancellation of the CTO on the first renewal and every second renewal thereafter unless an application has been made in the month preceding the renewal (section 39(2) of the Act).

5.7 Appeal of Review Panel’s Decisions

If an application is unsuccessful before the review panel the applicant or formal patient may appeal to Court of Queen’s Bench to have the review panel’s decision overturned.

• There are costs associated with filing the Court of Queen’s Bench appeal,
• The appeal must be commenced by Originating Notice within 14 days of the receipt of the review panel’s order or decision (section 43(1) of the Act),
• The appeal is a rehearing of the matter on the merits,
• The appeal is heard in private unless the Court directs otherwise (section 43(8) of the Act),
• The Court may direct that a transcript or minutes taken by the review panel be put into evidence along with any further evidence the Court considers necessary (section 43(4) of the Act), and
• The order of the Court of Queen’s Bench is final and not subject to appeal (section 43(5) of the Act).

5.8 The Formal Patient who has a Guardian under the Adult Guardianship and Trusteeship Act (AGTA)

When a person who has a guardian under the AGTA is admitted as a formal patient, he/she has the same rights as other formal patients under the Mental Health Act. The following questions and answers address clinical situations that may arise when the AGTA and the Mental Health Act intersect in practice.

Regarding the right to apply for review of certification

1. Can a formal patient with a guardian (under the AGTA) apply to a review panel in order to cancel certification without the guardian’s consent?

In our view, yes; however it is up to the review panel whether they will hear the formal patient’s application. Formal patients should seek advice from their legal counsel (e.g. Legal Aid).

Regarding consent to release health information to lawyer for the hearing

2. An adult formal patient with a guardian under the AGTA has applied for a review panel hearing. Can this patient consent to release of information for the facility to give the patient’s lawyer access to their health record for the purposes of the review panel hearing? Or is the guardian’s consent required?

Facilities have, in the past, taken different approaches to this question – some rely on section 104 of the Health Information Act (HIA) and some rely on section 35(1)(n) HIA. Either way, HIA may be interpreted so that the guardian’s consent is not required (although if the guardian is willing to consent, such consent will be accepted).
Regarding right to appeal physician’s certificate of incompetence

3. Further, if a formal patient has a guardian, and a Form 11: Certificate of Incompetence to Make Treatment Decisions is issued, is the patient able to make an application to the review panel and request that the physician’s certificate of incompetence be cancelled (without the guardian’s consent)?

Yes. Section 27(3) of the Act states that the patient is entitled to have the physician’s opinion reviewed by a review panel if the patient applies for the review by sending notice of application to the review panel chair in the prescribed form (Form 12: Application for Review Panel Hearing).

Regarding appeal to Court of Queen’s Bench

4. Can a formal patient with a guardian (under the AGTA) appeal review panel decisions to Court of Queen’s Bench without the guardian’s consent?

It is up to a Court as to whether they would “hear” an appeal. There is case law supporting the position that once a guardian has been given the authority to commence legal proceedings on behalf of a dependent adult (as is often granted in guardianship orders), the patient no longer has this authority. However, formal patients should seek advice from their legal counsel (e.g. Legal Aid) since counter-arguments exist.
1. **Can a formal patient or person subject to a CTO have an interpreter at the review panel hearing?**

   Yes. In order to hold a fair hearing the patient must be able to understand what is being said. It is up to the facility to obtain an interpreter.

2. **For what review panel hearings can the formal patient or person on a CTO request Legal Aid assistance?**

   Legal Aid duty counsel may become involved in six different types of hearings before the review panel under the *Mental Health Act*:
   - review of a physician’s certificate,
   - objection to treatment,
   - review of admission or renewal certificate,
   - review after six months,
   - return to correctional facility, or
   - review of CTOs.

3. **Do patients need the assistance of a lawyer in order to exercise their rights before review panels? What assistance is provided by Legal Aid?**

   Legal Aid Alberta has stated the following:

   Formal patients may present their own cases or be represented by a lawyer at a review panel hearing. In addition, if patients have an agent they may request their agent attend the hearing with them.

   Legal Aid Alberta can provide duty counsel to those patients who request their assistance at all review panel hearings in the province; there is no need to determine the patient’s financial eligibility.

   The lawyer appointed as duty counsel for Legal Aid will, if possible, see the patient the day before the hearing and will attend at the hearing. Duty counsel can present the patient’s case before the review panel, pose questions to anyone providing evidence and present a summation at the close of the hearing of evidence.

   A patient’s legal representative may visit the patient on the unit anytime. It may be possible for an available duty counsel to provide some assistance on the day of the hearing for those patients who decide (at the last minute) they want help. The difficulty is in not being prepared since counsel would not have had a chance to read the records or talked to the patient.
4. Can healthcare providers contact a lawyer/Legal Aid for or on behalf of a formal patient or person subject to a CTO?

Yes, upon a patient’s request and with the patient’s express consent to contact the legal counsel and disclose information to the legal counsel (such as the patient’s name, the fact that they are a formal patient or person subject to a CTO who wishes representation).

Legal Aid Alberta has stated the following:

Legal Aid duty counsel only assists those patients that request their assistance. Patients wishing legal advice or representation are responsible for phoning Legal Aid or letting staff know they want Legal Aid assistance. Legal Aid is sometimes provided with information from the hospital on those patients that have requested assistance.

5. How does legal counsel representing a formal patient obtain access to the patient’s health record prior to or during the review panel hearing?

Legal counsel representing the patient must first obtain authorization via the patient’s signed consent for release of health information, in accordance with the facility’s policies regarding the disclosure of health information.

The health record is then subject to line-by-line screening and severing of any information that falls within ‘exceptions’ (sections 7(2) and 11(1) of the Health Information Act (HIA)), or relates to ‘harm’ that must not be disclosed (section 11(2) of the HIA). Only then is a copy of the health record made available to counsel.

As examples: Information about the patient from a third party may not be severed unless it meets the section 11 test. ‘Exceptions’ include third party information written on the record that is not about the patient, but is, for example, about a family member or neighbor.

If the formal patient is incompetent with a guardian, refer to 5.8, question 2, of the guide for special considerations. The health record is still subject to screening and severing as per the above paragraph.

6. Are patients or legal counsel charged a fee when they request the health record for review panel hearings?

No; usual permitted fees associated with producing the health record are waived for patients under the Mental Health Act who request their health information for the purposes of review panel hearings.

7. At a review panel hearing, does the review panel have the right to access the original health record of a formal patient or person subject to a CTO?

Yes. Section 17(7)(f) of the Act provides for any health information to be disclosed to a review panel that is to hear an application from the person to whom the health information relates. (Also see section 37(1) of the Act and section 4 of the Public Inquiries Act.)

In practice, the review panel has access to the original health record for the purposes of the hearing and, in addition, is informed of any ‘exceptions’ where information has been severed and made unavailable to the patient and his legal counsel as a result of routine screening of the health record prior to the review (section 7(2) of the HIA).
8. **What if a patient or the review panel has concerns about the fact that health information was severed in records produced for review panel hearings?**

The custodian (e.g. Alberta Health Services) has discretion under section 11(1) of HIA to decide whether health information should be disclosed to the requesting individual. For example, if the disclosure could reasonably be expected to result in harm or threaten the safety of an individual or the public, then the custodian may sever the information from the record before a copy of the record is given to the person requesting the record.

However, given that the disclosure is to the patient's legal counsel for the purpose of a review panel hearing, information would likely only be severed under section 11(1) HIA when the custodian feels that there is a significant safety threat or confidentiality issue.

It is important to note that the custodian must sever health information pursuant to section 11(2) when the information falls within the categories listed in 11(2) – e.g. when the information is about an individual other than the patient, unless the health information was originally provided by the patient in the context of a health service being provided to the patient (the “patient” is the applicant; his lawyer is simply acting on the patient’s behalf). Refer to Chapter 8 of this guide for more detail.

In situations where the review panel or the patient or his/her counsel feels it is important to have the entire chart without severing, review panels have the power to compel the custodian to produce an unsevered copy of the health record. The custodian would want to make the review panel aware of its rationale for severing the document before the review panel issues the order, so the panel could consider potential patient safety issues. The HIA has an exception which allows custodians to comply with all proper subpoenas, warrants or orders issued by the review panels.

9. **What is the role of the patient’s physician and other health care providers in a review panel hearing?**

The review panel chair asks the physician (and sometimes other health care providers) to attend and speak to their knowledge of the patient based on history, treatment and assessment, and to provide observations of the patient’s mental status, behavior, risks, changes, improvement or deterioration since hospitalization. This information will be in the health record as well.

10. **Do patients need the assistance of a lawyer in order to exercise their rights before a Court of Queen’s Bench?**

No; patients can represent themselves in appeals to the Court of Queen’s Bench. However, Legal Aid services may be available for this purpose. Patients can also hire private legal counsel.

11. **Is there a cost to the patient for the Court of Queen’s Bench hearing when a patient is appealing the review panel’s decision?**

Court costs: Yes, a fee will have to be paid to the Court when the patient files the documentation commencing the appeal. For exact fees, individuals should phone the Court of Queen’s Bench directly.

Legal counsel costs: The patient can apply to Legal Aid (see next question) or if a patient would like private legal counsel, he/she will have to pay the lawyer’s fees (as negotiated between the patient and lawyer).
12. Does Legal Aid offer representation and/or assistance with costs to a formal patient requesting assistance with an appeal to Court of Queen’s Bench?

Legal Aid Alberta has provided the following information:

Decisions of the review panel may be reviewed by the Court of Queen’s Bench by way of an Originating Notice filed within 14 days after the receipt of an order or a written decision of a review panel.

A patient who wants to appeal a decision from the review panel to Court of Queen’s Bench may apply for Legal Aid coverage by completing a formal application to Legal Aid. There is no duty counsel program available for a Queen’s Bench appeal which means Legal Aid will not automatically take on the patient’s case.

At the time of application, Legal Aid contacts the lawyer who represented the formal patient at the review panel hearing to obtain an assessment of the case. Coverage by Legal Aid Alberta for Court of Queen’s Bench appeal is decided on the basis of merit. Duty Counsel may assist formal patients in the preparation of this Originating Notice but this does not cover the disbursement involved in filing the pleading.

The patient can appeal Legal Aid’s decision to refuse coverage. Legal Aid tries to proceed with that appeal process quickly. Dealing with these requests by phone or email vote, they quite often manage to get the appeal heard before the limitation date for filing with court of Queen’s Bench.

13. Should staff advise AHS Legal Services when a formal patient or person subject to a CTO is initiating an appeal to Court of Queen’s Bench?

Yes. Information may be provided (for staff and patient) which can support the patient’s appeal effort.

14. Who is responsible for initiating the “deemed application” under section 39 of the Act?

Section 39(1) of the Act states that the review panel chair shall cause the review panel to hear and consider cancellation of the patient’s certificates. However, in practice the deemed application for a formal patient is initiated by the unit on which the formal patient is detained. For this reason it is helpful if a designated facility has a system for recording and tracking formal patient’s admission and renewal certificate dates as well as the dates of any review panel applications - including those that were withdrawn or cancelled. Knowing which formal patient is eligible for a deemed application, the unit can advise the review panel chair in advance of the 6 month date.

Section 39(2) of the Act states that the review panel chair shall cause the review panel to hear and consider cancellation of the CTO. The person who is subject to the CTO is deemed to have applied to the review panel for cancellation of the CTO on the first renewal and every second renewal thereafter unless an application has been made in the month preceding the renewal (section 39(2) of the Act).

According to CTO Regulation section 9(1), the issuing psychiatrist is responsible for notifying the review panel of approaching deemed applications.

At the time of writing this guide, the review panel chairs request a month’s notice in order to make arrangements and confirm attendance at the hearing for a deemed application.
This chapter will cover

- why a certificate of mental incompetence to make treatment decisions is issued,
- why substitute decision-makers are necessary,
- what is meant by 'best interests',
- when second opinions are required,
- when and why a treatment order is issued,
- why formal patients including formal minors and physicians apply to a review panel,
- how review panel decisions about treatment orders and competency are appealed,
- questions about competence, consent and treatment decisions in practice,
**Introduction**

Decisions regarding competency to consent to treatment are separate from the determination of whether a person becomes a formal patient or subject to a community treatment order. In general, a competent patient can consent to treatment on their own behalf.

If a patient is not competent, consent is provided by a substitute decision–maker. This general rule applies regardless of whether the patient is a voluntary or formal patient. Similarly, consent to treatment is provided by the person subject to a CTO, if competent, or his/her substitute decision-maker if not.

There is a significant exception to this general rule: a physician may apply to the review panel to direct that treatment be administered despite a refusal provided by a competent formal patient or the substitute decision-maker of an incompetent formal patient.

**6.1 Competence**

The Act identifies a person as mentally competent to make treatment decisions if he/she is able to understand the subject matter relating to the decisions and able to appreciate the consequences of making or not making the decisions (section 26 of the Act).

Case law is helpful in interpreting the two part test in section 26. *Starson v. Swayze* (a 2003 Supreme Court of Canada case) is particularly useful. To meet the first component of the test, the person must have the cognitive ability to process, retain and understand information related to the treatment decision. They do not have to agree with any diagnosis of their illness but must be able to acknowledge their symptoms. To meet the second component of the test, the person must have the ability to appreciate the consequences of the decision to be made. The person does not have to actually appreciate the consequences. The person must have the ability to apply the relevant information to his or her circumstances, and be able to weigh the foreseeable risks and benefits of a decision or lack thereof.

Not all formal patients who agree to treatment are competent under the Act to consent; a physician makes the determination.

**6.2 Consent**

Healthcare providers should follow their facility’s or organization’s policy regarding obtaining consent from a patient or their substitute decision-maker.

**6.3 Certificate of Incompetence to Make Treatment Decisions**

The Act describes all the activities to be completed before treatment can begin for a formal patient who is considered not mentally competent to make treatment decisions. Each provision for treatment is balanced by the patient’s right to apply for review, to appeal the review panel’s decision and, in some cases, to object to treatment decisions.

**Issuance of a certificate of incompetence to make treatment decisions**

Section 27 of the Act provides that a physician who believes a formal patient is not mentally competent to make treatment decisions must prepare a certificate of incompetence to make treatment decisions (Form 11).

In practice, many physicians routinely seek a second physician’s opinion of the formal patient’s competence to make treatment decisions at the time of issuing the certificate of incompetence.
The Form 11: Certificate of Incompetence to Make Treatment Decisions (sometimes called a physician’s certificate)

- includes written reasons for the opinion that the patient is not mentally competent,
- must be provided to the formal patient, his/her agent, guardian, if any, and (unless the patient objects) the patient’s nearest relative,
- notifies the formal patient that he/she has the right to have the physician’s opinion about his/her competence reviewed by a review panel by sending a Form 12 application to the review panel chair, and
- informs the patient that he/she is entitled to representation from legal counsel.

Choosing a substitute decision-maker

After issuing the certificate of incompetence the physician must identify someone who can make treatment decisions on behalf of the incompetent formal patient.

See Chapter 7.4 for more information related to consent and competency for persons subject to a CTO.

6.4 Treatment Decisions Made by a Substitute Decision-Maker

Section 28 of the Act sets out how treatment decisions may be made on behalf of

- minors who are formal patients,
- minors who are subject to a CTO,
- formal adult patients who are not competent to make their own treatment decisions, and
- persons subject to a CTO who are not competent to make their own treatment decisions.

These treatment decisions may be made by an individual who is apparently mentally competent, available, willing to make the decisions and is

- the agent of the formal patient or person who is subject to a CTO,
- a guardian of the formal patient or person who is subject to a CTO,
- the nearest relative (as defined in the Act) in the case where the formal patient or person subject to a CTO does not have an agent or guardian, or the agent or guardian is not available or willing or cannot be contacted after every reasonable effort has been made, or
- if a formal patient or a person subject to a CTO does not have an agent, guardian or nearest relative, the Public Guardian.

Requirements of the substitute decision-maker

In order to Act as a substitute decision-maker, the individual must

- have been in personal contact with the formal patient or person subject to a CTO in the past 12 months,
- be willing to assume responsibility for making treatment decisions, and
- make a statement in writing certifying their relationship to the formal patient or person subject to a CTO, and the facts that establish that they meet the above requirements (section 28(2) of the Act).
Best interests for treatment decisions

Treatment decisions must be made in accordance with the best interests of the formal patient or person subject to the CTO. In determining the best interests, the following considerations apply under section 28(4) of the Act:

- the patient or person’s mental condition will be or is likely to be improved by treatment,
- the patient or person’s condition will deteriorate or is likely to deteriorate without treatment,
- the anticipated benefit from treatment outweighs the risk of harm,
- the treatment is the least restrictive and least intrusive that meets the requirements above.

6.5 Challenging the Certificate of Incompetence by Applying to a Review Panel

If the formal patient makes an application to the review panel chair for a review of a Form 11: Certificate of Incompetence to Make Treatment Decisions, neither the physician nor the board can act on the physician’s opinion pending the outcome of the application (section 27(4) of the Act).

Reasonable notice of the time, date, place and purpose of the review panel hearing must be given by the chair of the review panel to specified individuals (section 40(2) of the Act, and Form 13).

A hearing must be held and the decision made and communicated to the patient and his/her guardian (if applicable) within 7 days of when the review panel chair receives the application challenging Form 11 (section 40(3) of the Act, and Form 14).

The onus is on the board of the facility in which the patient is detained to prove that the physician’s opinion regarding mental competence is correct (section 42(b) of the Act).

If the review panel refuses to cancel the physician’s certificate of incompetence (Form 11), the formal patient has a right of appeal to the Court of Queen’s Bench (section 43(1) of the Act).

Similarly, the physician has a right of appeal if the certificate of incompetence is cancelled.

6.6 Second Opinion Regarding Competency when the Formal Patient Objects to Treatment

Some, but not all formal patients who are not mentally competent to make treatment decisions can object to the treatment decisions of a SDM and obtain a second opinion regarding their competency.

Section 28(5) requires a second opinion when the SDM is the patient’s agent or nearest relative. This step does not apply when the SDM is the patient’s guardian or the Public Guardian. The Act does not provide the reasons for this additional step when only certain categories of SDM’s are asked for treatment decisions.

Treatment cannot be given pursuant to the consent provided by the SDM who is an agent or nearest relative unless the second physician is also of the opinion that the patient is not mentally competent to make treatment decisions (section 28(5) of the Act).

To recap, if a patient states that he/she does not want the treatment consented to by a SDM who is an agent or nearest relative, the physician must get a second physician’s opinion regarding whether or not the patient is mentally competent to make treatment decisions.

If the patient objects to the treatment decision of a guardian or Public Guardian, under the Act a second opinion is not required.
However, as mentioned earlier, many physicians routinely obtain a second physician’s opinion at the time of issuing the certificate of mental incompetence.

6.7 Reasons to Apply to a Review Panel for a Treatment Order

The board or a physician may apply to a review panel using Form 12 for a treatment order in three circumstances:

- when the physician is unable to treat a competent formal patient because he/she will not consent to treatment and the board or physician believes treatment to be in the best interests of the patient, an application can be made to the review panel for an order directing that treatment be administered (section 29(2) of the Act),

- similarly, if the substitute decision-maker refuses to make decisions on behalf of the formal patient who is a minor or is mentally incompetent to make treatment decisions, the board or physician can apply to the review panel for a treatment order (section 29(2) of the Act), or

- if a second physician does not agree that the patient is incompetent to make his/her own treatment decisions.

In practice, a substitute decision-maker may refuse to make or consent to a treatment decision. This might be based, for example, on a patient’s previously voiced objection about a treatment that is being considered or the SDM’s belief that the treatment is not in the best interests of the patient. The SDM might also refuse to make the decision rather than risk compromising his/her relationship with the patient.

If a competent formal patient or an incompetent formal patient’s SDM (under section 28 of the Act) objects to any existing or proposed treatment, that treatment cannot be provided unless a review panel makes a treatment order under section 29 of the Act.

Response to review panel hearing application

Reasonable notice of the time, date, place and purpose of the review panel hearing must be given to the applicant, the patient and his agent/guardian, to one person designated by the patient, and, with the patient’s consent, his nearest relative (section 40(2) of the Act, and Form 13).

Within 7 days of when the review panel chair receives the application, a hearing must be held and the decision made and communicated to the patient and their agent/guardian (if applicable) (section 40(3) of the Act).

6.8 Best Interests Considerations in Treatment Orders

At the review panel hearing, the physician provides evidence and reasons why he/she is applying for a treatment order. Before making an order that treatment be administered, the review panel must be satisfied that (under section 29(3) of the Act)

- the attending physician has examined the formal patient,

- the proposed treatment is in the best interests of the formal patient, that is whether
  - the patient’s mental condition will be or is likely to be improved by treatment,
  - the patient’s condition will deteriorate or is likely to deteriorate without treatment,
  - the anticipated benefits from treatment outweigh the risks of harm, and
  - the treatment is the least restrictive and least intrusive treatment that meets the above requirements.
6.9 Second Opinion of Treatment – Best Interests

In addition to hearing evidence provided by the physician and reviewing factors considered in the best interests of the patient, the review panel may also authorize a psychiatrist who is not a member of the facility’s medical staff to provide an opinion on whether the proposed treatment is in the formal patient’s best interests (section 29(4)).

Decision by the review panel

- The review panel may either refuse to make a treatment order, or make an order directing that treatment be administered.
- The treatment order may be subject to any conditions that the review panel considers appropriate (section 41(1)(c) of the Act).
- The review panel’s decision is communicated on Form 15 with the date and notice that the decision can be appealed to Court of Queen’s Bench.

Court of Queen’s Bench Appeal

Appeals can be made in two circumstances:

- If the review panel makes an order directing that treatment be administered, the patient has the right of appeal to the Court of Queen’s Bench within 14 days after receipt of the decision (section 43(1) of the Act).
- Similarly, if the review panel refuses to direct that treatment be administered, the physician who applied for the treatment order has a right of appeal to the Court of Queen’s Bench.

Provision for treatment while the patient is appealing a treatment order issued by a review panel to the Court of Queen’s Bench

- The Act is silent on whether a formal patient can be treated in these circumstances. However, there is case law supporting the position that treatment can proceed/be continued after the review panel has issued a section 29 treatment order while the patient is appealing to the Court (until the Court renders a decision).
- A patient may, however, apply to the Court for a “stay” to prevent/stop treatment until the Court has heard the appeal.

If the treatment order is upheld by the Court of Queen’s Bench, no further appeals are possible.

6.10 Psychosurgery

Psychosurgery can never be performed on a formal patient unless the patient consents, and the review panel orders that the surgery be performed (section 29(5) of the Act). Electroconvulsive therapy (ECT) is not considered psychosurgery.

Meaning of “psychosurgery”

“Psychosurgery means any procedure that, by direct or indirect access to the brain, removes, destroys or interrupts the continuity of histologically normal brain tissue, or that inserts indwelling electrodes for pulsed electric stimulation for the purpose of altering behavior or treating psychiatric illness. "Psychosurgery“ does not include neurological procedures used to diagnose or treat intractable physical pain or epilepsy where these conditions are clearly demonstrable” (section 1(1)(m) of the Act).
1. **When a formal patient has a guardian is it necessary to assess the patient’s competence to consent to treatment or is it automatically the role of the guardian to be the substitute decision-maker?**

The *Act* does not address whether the formal patient’s competence has to be assessed when the formal patient has a guardian. It simply says “a physician who is of the opinion …” One factor the physician may base his opinion on is the fact that the formal patient has a guardian.

Section 27 of the *Act* states that if a physician is of the opinion that a formal patient is not mentally competent to make treatment decisions, the physician shall complete and file Form 11. Section 27(3) anticipates that a copy of the form will be given to the formal patient’s guardian (among others), thus it is reasonable to interpret that the legislature intended Form 11 to be filled out even when a formal patient has a guardian.

Section 28 provides that the formal patient’s guardian can be the incompetent formal patient’s decision maker for treatment decisions. Thus, if the issuance of Form 11 is not challenged under section 27, then the guardian automatically has decision making authority.

2. **Where in the *Act* does it specifically state that treatment cannot be provided without the patient’s informed consent?**

The common law (judge-made law) deals with requirements relating to consent to treatment. Case law has established that treatment without consent may be negligence or battery. As such, informed consent to treatment must be sought from patients or their substitute decision-makers.

This is reflected in section 29(1) of the *Act* which provides that “If a formal patient who is mentally competent to make treatment decisions or a person referred to in section 28(1) objects to any treatment the patient is receiving or will receive at a facility, the attending physician shall not administer the treatment unless the review panel makes an order under this section.”

There are exceptions: A review panel may order treatment under section 29 despite a formal patient’s refusal. Also, when the treatment is “emergency treatment” it can proceed without consent (so long as there are no known previously expressed wishes to the contrary).

3. **If a formal patient is mentally incompetent to make treatment decisions and objects to the treatment decisions made by a substitute decision-maker (SDM) when is a second physician’s opinion required?**

Section 28(5) requires this second opinion only when the SDM is the patient’s agent or nearest relative; this step does not apply when the SDM is the patient’s guardian or the Public Guardian.

4. **Can the guardian/parent/agent of a formal minor patient sign him/her out of hospital against medical advice?**

No. When a person is made a formal patient under the *Act*, no matter the age, the certificates are sufficient authority to detain the person in the designated facility until the certificates are cancelled by a physician, review panel, Court of Queen’s Bench or they expire (section 7(1) of the *Act*).
The parent/guardian/agent should be encouraged to discuss with the physician his/her concerns and reasons for wanting discharge of the formal minor. If there is no satisfactory resolution he/she can appeal to the review panel if not already done, or contact legal counsel and the Mental Health Patient Advocate.

5. How are mental health treatment decisions made on behalf of formal minors?

Section 28 of the Act deals with treatment decisions made on behalf of formal minors and creates a list of substitute decision-makers. That list should be consulted in order to determine the appropriate SDM. For best interest considerations for treatment decisions by the SDM for a minor see Chapter 6.4 of this guide.

Notwithstanding section 28 of the Act, it may be possible to argue that a “mature minor” who is a formal patient can make their own mental health treatment decisions. Healthcare providers should contact their in-house legal counsel or the Canadian Medical Protective Association as appropriate for legal advice in those circumstances.

6. How are mental health treatment decisions made on behalf of minors who are voluntary patients in a designated facility?

Section 28 of the Act only deals with treatment decisions made on behalf of minors who are formal patients or are subject to CTOs.

We begin with the presumption that a youth under the age of 18 does not have the mental capacity to consent to healthcare and treatment and that a minor’s parent/guardian has legal authority to consent to the healthcare and treatment on the minor’s behalf. In practice, the majority of minors coming to hospital for psychiatric care are brought in by guardians or parents who make treatment decisions on the minor’s behalf even if the patient is voluntary and is in agreement with the admission and treatment.

Depending on the assessment of a minor, the “mature minor principle” may apply, allowing the minor to make treatment decisions on his/her own behalf. In practice, this may be rare in the mental health context. Healthcare providers are encouraged to contact AHS Legal Services or Canadian Medical Protective Association for legal advice in these situations. Healthcare providers are also encouraged to reference their facility’s policies and guidelines regarding mature minors.

The following questions may be considered when determining whether or not the minor may be classified as a mature minor and therefore competent to make their own treatment decisions.

This list of considerations is taken from a 2009 Supreme Court of Canada decision dealing with mature minors:

- What is the nature, purpose and utility of the recommended medical treatment? What are the risks and benefits?
- Does the adolescent demonstrate the intellectual capacity and sophistication to understand the information relevant to making the decision and to appreciate the potential consequences?
- Is there reason to believe that the adolescent’s views are stable and a true reflection of his or her core values and beliefs?
- What is the potential impact of the adolescent’s lifestyle, family relationships and broader social affiliations on his or her ability to exercise independent judgment?
- Are there any existing emotional or psychiatric vulnerabilities?
- Does the adolescent’s illness or condition have an impact on his or her decision-making ability?
- Is there any relevant information from adults who know the adolescent, like teachers or doctors?
The preceding list of considerations is **not exhaustive**; healthcare providers are encouraged to contact their organization’s internal legal services (e.g. AHS Legal Services) to obtain a more comprehensive list of considerations.

7. **Can a substitute decision-maker under the Act be from outside of Alberta?**

The legislation does not mandate that the agent, guardian or nearest relative be from Alberta. In choosing a substitute decision-maker, section 28 of the Act directs that the person be apparently mentally competent, available and willing to make the decision etc. In practice, geographic proximity to the patient facilitates availability for discussion and decision-making.

8. **If an incompetent formal patient’s nearest relative (e.g. the patient’s spouse) meets the criteria for SDM but declines to be the SDM, is the next choice for SDM the son or daughter or the Public Guardian?**

The next choice in this scenario would be the ‘son or daughter’ pursuant to section 1(i) of the Act. The Public Guardian is only the substitute decision-maker where there is no agent, guardian or ‘nearest relative’ (as that term is defined in section 1(1)(i) of the Act).

9. **If a formal patient or person subject to a CTO has expressed wishes while competent, do those wishes have to be taken into account by their substitute decision-maker when making treatment decisions on their behalf?**

“Expressed wishes” are not addressed in the Act; in Alberta the substitute decision-maker must make decisions in the formal patient’s (or person subject to a CTO) best interests and is not bound by the patient’s prior expressed wishes. Best interests criteria are set out in section 28(4) of the Act.

However, there may be a conflict where a patient has written clear instructions in their personal directive since section 14 of the Personal Directives Act provides that the agent must follow the patient’s clear instructions. In that instance, legal advice should be obtained.

10. **How does the Mental Health Act work with the Alberta Guardianship and Trusteeship Act (AGTA) with regards to an adult who lacks capacity and is a formal patient (e.g. non-emergent treatment)?**

If a mental health treatment decision is needed for an adult who lacks capacity and is a formal patient, look to section 28 of the Act, which allows such decisions to be made by the patient’s agent (under a personal directive) or guardian (as per Court Order granted under the former Dependent Adults Act or under the new AGTA).

• If the formal patient does not have a guardian or agent, or the agent or guardian is not available or willing or cannot be contacted after every reasonable effort has been made, then the formal patient’s nearest relative (as defined in the Act) can make the decision.

• If there is no one to make the decision after looking at all of the foregoing, then the Public Guardian can make the decision.

• Co-decision-making orders, supported decision-making, or specific decision-makers, as outlined in the AGTA, are irrelevant in this situation and should not be regarded with respect to mental health treatment for adults who lack capacity, who are formal patients or who are subject to a CTO (section 88(2)(e) of the AGTA).

If a treatment decision relating to the patient’s physical health is needed for an adult who lacks capacity and is a formal patient look to the AGTA (together with the Personal Directives Act) as to whom can consent to such treatment.
6.12 Flowchart and Key Points:
Formal Patient Competency and Consent for Treatment Decisions
See Key Points for reference details A-N (over). This Chart is one of three, only explanations specific to this chart are included.

- Review Panel decisions can be appealed to the Court of Queens Bench
- Patient may access Patient Advocate services at any time after 1st Certificate
Formal Patient Competency and Consent - Key Points

A. Definition of Mental Disorder (see MHA 1(1))

- A substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life.

B. Apprehension by Warrant or Peace Officers Statement (see MHA 10 and 12)

To apprehend a person to conduct an examination, the Judge and/or the Peace Officer must have reasonable and probable grounds to believe that the person is in a condition likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment and:

- Judges Warrant: (section 10, Form 8)
  - There is no other way to arrange for an examination.
  - Application supported by sworn information that the person is suffering from mental disorder.
- Peace Officer: (section 12, Form 10)
  - The person is suffering from a mental disorder.
  - The person should be examined for their own safety or the safety of others.
  - Circumstances are such that proceeding under section 10 would be dangerous.

C. Three Criteria for Formal Patient Certification (see MHA 2(a-c))

- Suffering from a mental disorder.
- In a condition likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment.
- Unsuitable for admission to a facility other than as a formal patient.

D. Admission Certificates

Effect of One Admission Certificate (see MHA 4(1))

- Gives sufficient authority to:
  - Care for, observe, assess, detain and control, apprehend and convey to a facility within 72 hours of issue.
  - Care for, observe, assess, detain and control the person during apprehension and conveyance.
  - Care for, observe, examine, assess, treat, detain and control the person for up to a maximum of 24 hours after arrival at facility unless a 2nd certificate is written.

Effect of Two Admission Certificates (see MHA 7(1-2))

- Gives sufficient authority to:
  - Care for, observe, examine, assess, treat, detain and control the person named on the certificate for up to one month after issuing of the certificate.
  - One certificate must be signed by a physician on staff at the facility.
  - If needed, Renewal Certificates must be completed prior to expiry of existing certificates.

E. Informing Patient and Others (see MHA 14)

Who*

- Patient
- Patient’s agent, substitute decision maker (SDM)
- Patient’s nearest relative (unless patient objects)
- Patient may designate one person s. 14 (1) & (4)

What

- The reason for issuance of the certificates.
- The authority for detention and the period of it.
- Function of the review panel.
- Notice of the right to apply for a review panel hearing to appeal treatment orders, certificates or finding of incompetence.

I. Mental Competency (see MHA 28)

Competency means that the person is able to understand the subject-matter relating to, and the consequences of, making treatment decisions or giving consent & the consequences of not doing so.

- Treatment decisions may be made on behalf of a formal patient when the patient is a minor or is not mentally competent by (in the following priority order):
  - Agent of the patient (under personal directive).
  - Guardian of the patient.
  - Nearest relative as defined in section 1(1)(i).
  - The Public Guardian (last resort).

The authorized person shall make the treatment decisions in accordance with what they believe to be the best interests of the patient.

Additional Information

- Formal Patient Certificates (admission / renewal) are cancelled on the issuance of a Community Treatment Order. (MHA 9.1(3))
- On admission as a formal patient, the Community Treatment Order should be cancelled (MHA 9.6(4c))
- Mental Health Patient Advocate services available at any time.

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<td>Review Panel Chair</td>
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This chapter will cover

- why community treatment orders (CTOs) were created,
- what conditions/criteria must be met before a CTO is issued,
- how a designated physician can assume CTO-related duties if a psychiatrist is unavailable,
- how consent is handled,
- what is the exception to the need for consent,
- how treatment and care plans are developed,
- what information is contained on the CTO,
- how the person and others are notified of the CTO and rights under the Act
- how and when the person subject to a CTO can apply to review panel,
- why and when CTOs are renewed, amended, cancelled or expire,
- what happens if a person fails to comply with the CTO,
- what processes provide for apprehension and conveyance to a facility when a person is not complying with a CTO,
- questions about community treatment orders in practice, and
- Flowchart and Key Points: Community Treatment Orders (CTO)
Background

Community treatment orders are largely dealt with in section 9 of the Mental Health Act, although there are references elsewhere (e.g., treatment decisions on behalf of the person subject to a CTO, section 28 of the Act). The Community Treatment Order Regulation (“CTO Regulation”) further clarifies the Act in areas such as

• how examinations can be conducted for the purpose of assessing whether an individual should be subject to a CTO (section 2 of the CTO Regulation),
• supervision of CTOs (section 3 of the CTO Regulation),
• how treatment or care is provided (section 4 of the CTO Regulation),
• designation of a physician where no psychiatrist is available (section 5 of the CTO Regulation),
• how circumstances are addressed when a person subject to a CTO is non-compliant (section 6 of the CTO Regulation),
• copies of documents to be provided (section 7 of the CTO Regulation),
• responsibilities of the issuing psychiatrist and the person responsible for supervising the CTO (section 8 of the CTO Regulation), and
• review on renewal of CTOs (section 9 of the CTO Regulation).

7.1 Introduction to Community Treatment Orders

Community treatment orders (CTOs) are a new approach in Alberta and were implemented in January 2010. CTOs expand addiction and mental health service options available to patients and healthcare providers.

CTOs are intended for persons with serious and persistent mental disorders who have demonstrated that without community treatment and support, they will experience recurring relapses and hospitalizations - frequently as formal patients. The purpose of CTOs is to provide these individuals with the particular treatment and care they require in the community thus breaking the cycle of admission-discharge-readmission.

Both adults and minors, formal and voluntary inpatients may be appropriate for a CTO. In fact, readiness for discharge from hospital can be facilitated by CTO support and supervision. Additionally, CTOs can be initiated with clients in the community, as long as all of the criteria are met.

In Alberta, a CTO is not court ordered nor are persons subject to a CTO considered formal patients. When a CTO is issued, a formal patient’s admission or renewal certificates are automatically cancelled (section 9.1(3) of the Act). In many (but not all) circumstances, the person, or someone acting on his/her behalf under section 28 of the Act, must give his/her consent for a community treatment order to be issued.

As well, the context and process of issuing a CTO differs from that of writing admission or renewal certificates under the Act. Certifying a patient occurs fairly quickly in response to legislative requirements and the immediate, often urgent, need to detain a patient in a designated facility. Conversely, issuing a CTO may take place over a number of days or weeks as the various components are considered and arranged (e.g., care, treatment, consent, signatures).

7.2 Applicability and Criteria for Issuance of a CTO

In practice, the psychiatrist or designated physician may determine a person meets the criteria for issuance or renewal of a CTO, but undertake treatment planning and obtain required signatures.
before examining the person for the purpose of completing Parts I and II of Form 19 or 20. This practice reflects the length of time that is required to complete the planning and signing processes and ensures actual examinations take place within the preceding \textbf{72 hours} of the issuance of the CTO.

Section 9.1 of the \textit{Act} identifies the criteria that must be met when two physicians, one of whom must be a psychiatrist, issue a community treatment order (Form 19). To be placed on a CTO the physicians must each believe

- that the person is suffering from a mental disorder.

Additionally, the two physicians must be of the opinion that one or more of the following three conditions apply:

- within the immediately preceding 3-year period the person has on two or more occasions, or for a total of at least 30 days:
  
  (i) been a formal patient in a facility; and/or
  
  (ii) been in an approved hospital or been detained in a custodial institution, where it is evident that he/she would have met the criteria to be detained as a formal patient;

- the person has within the preceding 3-year period been subject to a CTO; or

- the person has, while living in the community, exhibited a pattern of recurrent or repetitive behaviour that indicates that the person is likely to cause harm to him/herself or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community.

The two physicians after separate examinations within the preceding 72 hours must be of the opinion that all of the three following conditions apply:

- the person is likely to cause harm to themselves or others, or to suffer substantial mental or physical deterioration or serious physical impairment if they do not receive continuing treatment or care while living in the community, and

- the treatment or care the person requires exists in the community, is available to the person and will be provided to the person, and

- the person must be able to comply with the treatment or care requirements in the CTO.

Finally, the person must either be willing to consent to the CTO or the circumstances are such that consent is not needed.

\textbf{Examination by video conference}

In order to facilitate examinations of persons in the community and rural areas, section 2 of the CTO regulation explicitly permits remote examinations by way of video conference, or other appropriate technology, for the purpose of issuing CTOs and for examinations related to apprehension orders.

\textbf{7.3 Lack of Availability of a Psychiatrist – “Designated Physician”}

If a psychiatrist is unavailable to issue, renew, amend or cancel a CTO, or issue an apprehension order for a person under a CTO, a board or a regional health authority may designate a physician to assume this responsibility, using Form 25 (section 9.7 of the \textit{Act} and section 5 of the CTO Regulation). This “designated physician” responsibility is valid for up to 2 years and may be renewed.

Only after consultation with a psychiatrist can a “designated physician” complete the CTO forms to issue, renew, amend or cancel a CTO, or issue an apprehension order for a person under a CTO.
7.4 Competency, Consent to a CTO and Consent to Treatment

Overview

• the person’s competence to consent is addressed,
• if the person subject to the CTO is not competent to consent, a substitute decision-maker (SDM) is selected,
• if no one can or will consent, exceptions to consent are considered,
• consent to a CTO is separate from consent to treatment,
• unless relying on an exception, signed consent is required to complete the issuing or renewal of a CTO.

Competency

Section 26 of the Act states that “a person is mentally competent to make treatment decisions if the person is able to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions”.

A person’s competence should be assessed by a physician to determine whether he/she is able to consent to the CTO. As a general rule, the person named in the CTO or their SDM must consent to the CTO being issued. If he/she is not competent, this fact as well as any reasoning for the conclusion regarding capacity must be documented in the health record. (Note: this competency assessment is independent of a Form 11 which may have been completed while the person was a formal patient.)

Selection of a substitute decision-maker

If the person who will be subject to the CTO is not competent to consent

• a SDM’s consent must be provided by a person who is competent to make decisions on the person’s behalf,
• selection of a SDM must be made in accordance with sections 28(1) and 28(2) of the Act,
• SDM decision-making considers the person’s best interests (section 28(4) of the Act), and
• a SDM can consent to a CTO on the person’s behalf (in Part V, Form 19 or 20), as well as consent to the person’s treatment provided in accordance with a CTO (usually through a separate process with the treatment provider).

Exceptions to consent — Issuing a CTO without consent

If the person who will be subject to the CTO, or his/her SDM if applicable, refuses to consent to the issuing or renewal of the CTO, the issuing psychiatrist or “designated physician” will need to determine whether or not to proceed.

A CTO can be issued without consent if the person has, while living in the community, exhibited a history of not obtaining or continuing with treatment or care that is necessary to prevent the likelihood of harm to others and a CTO is reasonable in the circumstances and is less restrictive than detaining the person as a formal patient.

It is important to note that this exception to the requirement for consent is applicable only if there is potential harm to others, not harm to self or risk of deterioration.
Consent to treatment

Consent to treatment is separate from consent to a CTO. Regardless of whether the CTO is issued with or without the person's consent (as outlined in the "exceptions to consent" described previously), informed consent to treatment must be obtained before any treatment is provided.

- Healthcare providers should follow their facility's or organization's policy regarding obtaining consent to treatment.
- When a SDM consents to treatment on behalf of a person subject to a CTO, a separate/additional consent form is necessary.

Signatures - Part V: Consent

The issuing or renewal of a CTO is not complete without the signing of the consent portion in Part V of Form 19 or 20. There are three options identified, and one of them must be completed:

- consent by a person subject to a CTO,
- consent by a SDM, or
- no consent - the criteria for issuing a CTO without consent are restated and the issuing psychiatrist must sign Part V.

7.5 The Process of Treatment and Care Planning

Having established that the person meets the criteria for a CTO, the psychiatrist or “designated physician” works with a treatment team to prepare a proposed plan of treatment and care and to ascertain that the required supports, treatment and care exist in the community, are available and will be provided to the person.

The treatment and care plan is integral to the issuance of a community treatment order and is included in Form 19. It lists all the service providers who have agreed to provide services and/or supports for the person subject to the CTO, for instance, medications, medical appointments, clinical tests and other aspects of care specific to the person's needs. Thus, the development of the treatment and care plan should be done collaboratively, and include minimally

- the issuing psychiatrist or “designated physician”,
- supervising physician (if this is not the issuing psychiatrist),
- treatment team,
- the person subject to the CTO - and their substitute decision-maker if there is one, and
- any other person, group or organization that will provide treatment or care to the person in the community.

Ongoing supervision of the person subject to a CTO can only be provided by a psychiatrist or physician (section 3 of the CTO Regulation).

Note: because the person who is subject to the CTO must be able to comply with the requirements in the CTO he/she should always be involved in the development of the CTO even if he/she is not competent to consent.

The physician issuing the CTO should meet with the patient and their SDM, where applicable, to review the purpose of the CTO, the conditions it contains and the treatment and care plan. The meeting provides an opportunity for the person to communicate his/her willingness to participate in and follow the requirements of a CTO. The physician should also review the person's rights relative to the CTO.
7.6 Contents of the CTO

Form 19 is used for issuance and Form 20 for renewals of CTOs. Amendments to CTOs are noted on Form 21. Under section 9.1(2) of the Act, the CTO must

- identify and be signed by the issuing physicians,
- note the dates and locations (facility and town) where the examinations occurred,
- explain the physicians' separate rationales for issuing the CTO,
- identify the treatment or care plan, the individual responsible for supervision, and any reporting obligations, and
- satisfy any other requirements provided for in the regulations (e.g. CTO Regulation section 4: signature of the person authorizing services to be provided by regional health authority).

Duration of the CTO

A CTO will be in effect for an initial 6 months after the day it is issued and will automatically expire unless two physicians (one of whom must be a psychiatrist or a “designated physician”) renew it for another 6 months. There is no limit to the number of times a CTO may be renewed. There are automatic reviews of a CTO built into the legislation and also opportunities for the person to request that their CTO be cancelled.

7.7 Forms and Signatures

It is important that the information written on the CTO is legible. The documents must fulfill legislative requirements to state the reasons for the issuance of the CTO, as well as contain all necessary signatures and dates.

- The names of the person subject to the CTO, psychiatrists, physicians, and treatment and care providers must be readable.
- The identified treatment, care and accompanying dates must be legible.
- A CTO is a legal document and is evidence of the terms and conditions the person must follow to comply with the community treatment order.

  Treatment teams may consider using a signature log, that is, a listing of names and signatures for everyone named on the CTO.

Forms 19 and 20 for issuance and renewal of a CTO

These are five-part forms that must be completed and signed by the following individuals

- Part I: examining psychiatrist or “designated physician”,
- Part II: second examining physician,
- Part III: the treatment or care provider(s) or the signature of a person authorized by a regional health authority (e.g. AHS) when the treatment/care is provided by that regional health authority,
- Part IV: psychiatrist or physician accepting responsibility for supervising the CTO, and
- Part V: person or the SDM consenting to the CTO, or, if the CTO is being issued without consent, then the signature of the issuing psychiatrist or “designated physician”.

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Signature to be provided by regional health authority representative

If any services are to be provided by a regional health authority (e.g. AHS), that regional health authority’s representative

• must sign Part III of the CTO before it becomes effective, and

• must sign any amendments to the treatment or care plan before they become effective (section 4 of the CTO Regulation).

Copies of forms

Appendix VI provides specific information regarding the completion and distribution of all CTO forms.

The issuing psychiatrist or “designated physician” must provide a copy of each CTO and any associated completed forms to the regional health authority as set out in the Mental Health Act Forms Regulation (section 7 of the CTO Regulation). This is in addition to providing copies to the person and their SDM (if applicable, etc. as outlined in 7.8 Rights and Notification below).

The regional health authority must then promptly provide copies to:

• the person responsible for supervising the CTO if that person is not the issuing psychiatrist, and

• the person who is responsible for providing the “written statement” as set out in section 8 of the CTO Regulation,

• any other regional health authority providing services to the person subject to the CTO. (Note: although in 2010 AHS is the sole regional health authority, it is recommended to distribute copies to the AHS contacts in applicable zones, facilities, and communities.)

7.8 Rights and Notification

Persons subject to a CTO, whether minors or adults, have certain rights which are protected under the Act. Section 8 of the CTO Regulation requires the issuing psychiatrist to prepare and provide a written statement on Form 26 and a copy of the issued, amended or renewed CTO (Form 19 or 20) with the following information:

• the reason for the issuance, amendment or renewal of the CTO,

• the authority for the issuance, amendment or renewal of the CTO,

• information regarding the function of review panels,

• the name and address of the chair of the appropriate review panel, and

• the right of the person subject to the CTO to apply to the review panel for cancellation of the CTO (section 14(1.1)(a) of the Act).

This written statement (Form 26) is given to:

• the person subject to the CTO,

• a person who exercises the authority to make treatment decisions on the person’s behalf under section 28 of the Act,

• any persons providing treatment or care to the person subject to the CTO,

• an individual designated by the person subject to CTO (section 14(4) of the Act), and
• any other person noted in the CTO Regulations (section 14(1.1)(b) of the Act).

Appendix VI provides specific information regarding the completion and distribution of all CTO forms.

Verbal explanation

Generally it is not sufficient to present only the written statement to the person subject to a CTO and/or his/her SDM. Information, including the function of the review panel and Mental Health Patient Advocate (the Advocate), should also be communicated verbally, in simple language.

Interpreter

In the event of a language difficulty, an interpreter must be obtained and the above information and the written statement must be provided in the language spoken by the person subject to the CTO, or their guardian (section 14(2) of the Act).

Mental Health Patient Advocate

The role of the Advocate extends to a person subject to a CTO (section 45(1) of the Act). The person is advised that he/she may contact the Advocate for rights information, expression of concerns, and complaints about his/her rights, care and treatment. The Advocate is authorized to investigate and resolve such complaints.

Written material

Brochures about CTOs, Review Panels, Legal Aid and the Mental Health Patient Advocate are available to be given the person subject to the CTO and their SDM.

A. The following brochures are available for downloading at the Government of Alberta Health & Wellness website: www.health.alberta.ca/newsroom/pub-mental-health.html
   - Community Treatment Orders – December 2009
   - Review Panels: Community Treatment Orders – December 2009

B. The Mental Health Patient Advocate provides both a brochure and poster which can be ordered by contacting: info@mpha.ab.ca
   - View Brochure - You Have Rights Under the Mental Health Act - Here to Help You

C. Legal Aid Alberta provides no cost brochures. Ask for the brochure titled,
   - “Do you need affordable, professional legal assistance?”
     www.legalaid.ab.ca/resources/Pages/brochures.aspx#content

D. Mental Health Act forms, including Form 12 - Application for Review Panel Hearing are available on the AHS website: www.albertahealthservices.ca/1256.asp

7.9 Application to a Review Panel

An individual subject to a CTO can request cancellation of their CTO by completing Form 12 - available from their physician, case manager or other mental health staff working with the individual. The completed Form 12: Application for Review Panel Hearing is mailed or faxed to the review panel chair (section 38(1.1) of the Act).
When a review panel chair receives an application for review of a CTO outside its geographic area, the application will immediately be forwarded by the chair to the appropriate review panel chair (CTO Regulation section 9(2)).

There are three review panels in Alberta:

- **Calgary and South Mental Health Review Panel**
  (covering AHS Zone 1: Southern Alberta, and AHS Zone 2: Calgary)

- **Central Alberta Mental Health Review Panel**
  (covering AHS Zone 3: Central Alberta) and;

- **Edmonton and North Mental Health Review Panel**
  (covering AHS Zone 4: Edmonton, and AHS Zone 5: Northern Alberta)

Review panel hearings are held in the area in which the person subject to the CTO resides. If the distance to travel to the hearing would be too great, video conferencing hearings may be arranged. In practice, the team working with the applicant may assist the review panel chair in organizing the hearings to ensure all appropriate parties are engaged and all necessary clinical information (e.g. CTOs, amendments, current health record documentation, if any) is available for review panel consideration and decision making (section 17(7)(f) of the Act).

The hearing to consider cancellation of a CTO is held within 21 days of the application being received by the review panel chair. The review panel can cancel or uphold (refuse to cancel) a CTO but they cannot amend it. A review panel can cancel a CTO if the criteria (excluding the requirement for consent or the criteria meeting the exception for consent) are not met.

If the application is unsuccessful, the person who is subject to the CTO has a right to appeal the review panel’s decision to the Court of Queen’s Bench (section 41(3) of the Act.) (See Chapter 5 in this guide for further information about review panels.)

**Deemed application**

A person who is subject to a CTO is deemed to have applied to the review panel for cancellation of the CTO on the first renewal and every second renewal thereafter unless an application for cancellation has been made in the month preceding the renewal (section 39(2) of the Act). The review panel chair requests a month’s notice in order to have arrangements made and confirm attendance at the hearing.

The person subject to the CTO and his/her SDM, if any, receive at least 7 days notice of the date, time, place and purpose of the deemed application hearing from the review panel chair (section 40(1) of the Act). The chair also advises the person of his/her right to Legal Aid/legal representation; both factors (notice and information) allow time for the individual/SDM to make arrangements.

According to CTO Regulation section 9(1), the issuing psychiatrist is responsible for notifying the review panel of approaching deemed applications.

### 7.10 CTO Renewal, Amendment, Cancellation or Expiry

**Renewal**

CTOs expire 6 months after the day they are issued unless they are renewed (Form 20) or cancelled (section 9.2 of the Act). A CTO may be renewed at any time before its expiry for a period of 6 months (section 9.3 of the Act). There is no limit on the number of renewals allowed.
Amendments

The regulations provide a procedure for amending conditions of the order. The person subject to the CTO may request amendments and, generally speaking, conditions can be amended by a psychiatrist (in communication with the person subject to the CTO) at any time. However, the onus remains on the psychiatrist to ascertain whether the required treatment or care is available and will be provided to the person, and whether the person has the ability to comply with the terms of the CTO. A psychiatrist amends a CTO using Form 21: Amendments to Community Treatment Order (section 9.4 of the Act).

Form 19 (Part III) states that medication may be adjusted where indicated by clinical need. In practice, if the medication indicated on the CTO is listed by class (antipsychotic, antidepressant, mood stabilizer, antianxiety, etc.), rather than specific medication and dosage, an amendment is not required when making adjustments to dosage or medications within the same class. An amendment (Form 21) would then be required if the medication is changed from one class to another.

Cancellation

Section 9.5 of the Act specifies that CTOs may be cancelled at any time by a psychiatrist using Form 22, if criteria set out in section 9.1(1)(b) to (d) cease to apply. Note that criteria for consent, or exceptions to consent, are not included in section 9.5 of the Act.

In a situation where a person subject to a CTO or, if applicable, his/her SDM, no longer agrees to the CTO, he/she may discuss this with the physician who is supervising the CTO. A psychiatrist or “designated physician” may, as appropriate, amend or cancel the CTO or issue an admission certificate for the person.

The person also has the option to apply to the review panel for cancellation of the CTO. The review panel will either cancel or refuse to cancel the CTO. Note, however, that pursuant to section 38(1.1) of the Act, consent is not a criteria that has to be met in order for a review panel to uphold the CTO. Section 42(2) provides that the review panel will consider whether criteria 9.1(1)(a) to (e) of the Act are met.

Notice of cancellation or expiry of CTO

When a CTO expires or is cancelled, Form 22: Community Treatment Order Cancellation or Expiry must be completed, including recommendations for continued treatment or care.

• The person subject to the CTO must be advised.

• Notification is given to individuals who were formally notified when the CTO was issued, as well as the person’s family doctor (if known) (section 14(5) of the Act).

Notification is given and Form 22 is completed and distributed by a psychiatrist or “designated physician” upon cancellation, and by the supervising physician upon expiry of a CTO.

Only a psychiatrist or “designated physician” may complete a renewal, amendment or cancellation of a CTO. Therefore, if the supervising physician is not a psychiatrist or “designated physician”, he/she will need to involve someone in the process who is authorized to complete the form.

7.11 Failure to Comply

Reporting requirement

Individuals identified on the order who provide treatment or care to persons subject to a CTO must report any failure of the person to comply with treatment or care under the CTO to the appropriate regional health authority within 24
hours of becoming aware of the failure to comply (sections 6(1) and (2) of the CTO Regulation). The notice must be provided on Form 27: Community Treatment Order Non-compliance Report.

Upon receiving notice of failure to comply with treatment or care (Form 27), the regional health authority is obligated to provide copies of the form to the physician responsible for supervision of the CTO within 24 hours (section 6(3) of the CTO Regulation).

Consequences of non-compliance with a CTO

If a person subject to a CTO is not in compliance with the treatment or care in the CTO, an apprehension order may be issued. The legislation requires that, prior to issuing an apprehension order, a psychiatrist must be satisfied that reasonable efforts have been taken to inform the person, and if applicable the SDM, that there is non-compliance and the need for compliance.

The person subject to the CTO must be provided with reasonable assistance to enable him/her to comply with the treatment or care in the CTO and be advised of the consequences of non-compliance which include

- an order for their apprehension and conveyance to a facility for examination may be issued, and
- the possible consequences of this assessment include being admitted to a designated facility and detained as a formal patient.

Only a psychiatrist or “designated physician” may complete the CTO apprehension order. Therefore, if the supervising physician is not a psychiatrist or “designated physician”, he/she will need to involve someone in the process who is authorized to complete the form.

A person cannot be forced to accept treatment or care or comply with the treatment or care outlined in a CTO. If he/she is not complying, the treatment team will follow the steps outlined above – to support and inform the person, perhaps amend the CTO and advise him/her of the consequences of continued noncompliance. Consequences include having the person taken to hospital for examination with a possible outcome of admission as a formal patient.

7.12 Processes for Apprehension and Conveyance of a Person not Complying with a CTO

There are three processes whereby a peace officer may apprehend and convey a person not complying with a CTO to a designated facility for examination:

1. By carrying out a CTO apprehension order (Form 23)
   - completed and signed by a psychiatrist or “designated physician” who, despite efforts to support the person’s compliance with the CTO, has reasonable grounds to believe the person subject to a CTO has failed to comply with the CTO,
   - Form 23 gives a peace officer authority to apprehend the person including the entering of premises and the use of physical restraint, as well as to take into custody, care for, detain and control the person during conveyance to a specific facility to be examined (section 9.6(1) of the Act),
   - the psychiatrist must indicate on the apprehension form a specific facility to which the patient must be conveyed,
   - the order expires 30 days after being issued (section 9.6(3) of the Act).
2. By carrying out a judge’s warrant (Form 8)

- issued when someone brings information under oath before a judge about a person subject to a CTO regarding the informant’s reasonable and probable grounds to believe the named person is not complying with their CTO (Form 7),

- if the judge believes that the person is likely to cause harm to themselves or others, or to suffer substantial mental or physical deterioration or serious physical impairment, and is not complying with their CTO, and an examination cannot be arranged in another way, the judge may issue a warrant (Form 8),

- the warrant authorizes peace officers the authority to apprehend and convey the named individual to a facility for examination (section 10(5) of the Act),

- the warrant to apprehend the person expires in 7 days (section 10(7) of the Act). A peace officer may under oath request a judge to extend the warrant for a further 7 days (section 11 of the Act). Form 9 is used to extend the warrant.

3. By acting pursuant to section 12(1) of the Act under peace officer discretion (Form 10)

In order to apprehend and convey, the officer must have reasonable and probable grounds to believe that

- a person is suffering from a mental disorder,

- is subject to a CTO and is not complying with the CTO,

- the person should be examined in the interests of the person’s own safety or the safety of others, and

- the circumstances are such that to proceed under section 10 would be dangerous.

Examination at a facility

As soon as practicable and at the most within 72 hours of being conveyed to a facility under Form 23, Form 8 or Form 10, the person subject to the CTO must be examined by two physicians, one of whom must be a psychiatrist (Form 24). Under section 9.6(4) of the Act, the two physicians must each decide whether

- the CTO should be cancelled, and the person should be released without being subject to the CTO,

- the CTO should continue, amended as necessary, or

- the CTO should be cancelled and the person should become a formal patient, with admission certificates issued.
1. **When a CTO is issued on formal patients are their admission/renewal certificates automatically cancelled or is the physician required to write a “cancel certificate” as well?**

Section 9.1(3) of the Act states that “the certificates of admission or renewal for a formal patient are cancelled on the issuance of a community treatment order”. Therefore it is reasonable to interpret this section as meaning that the certificates are automatically cancelled when a CTO is written.

2. **Who can issue, renew, amend and cancel CTOs?**

A psychiatrist or a physician designated under section 9.7(1) of the Act may do so. (See section 5(1) CTO Regulation.)

Although the Act refers to “designated physician or health professional”, according to CTO Regulation section 5(1) only a physician may be designated under section 9.7(1). The designation of a physician is done formally by the regional health authority. This provision was to facilitate CTOs being written and managed in areas where no psychiatrist is available. If a physician is designated, he/she may issue, renew, amend or cancel a CTO or issue an apprehension order only after consultation with a psychiatrist. The designation must be documented on Form 25: Community Treatment Order Designation of Physician.

3. **What can be included in the CTO treatment and care plan?**

Since CTOs are new there is currently little guidance from Alberta courts regarding how far reaching the requirements in CTOs can be; it is up to the issuing psychiatrist to determine what provisions they feel can validly be part of a CTO. A CTO treatment and care plan will be specific to the individual, their needs and goals. This could include, for instance, medications, clinical tests and other aspects of care. As a legal document a CTO should not include unattainable stipulations or provisions.

4. **Is it necessary to document on a health record in addition to completing CTO forms?**

The Act does not speak to this but a prudent clinician would document on a person’s health record, for example, the reasons for implementing a CTO, the discussion about consent and treatment planning, why a CTO was amended, how non-compliance was handled and under what circumstances a CTO was cancelled. These are just a few examples of documentation that can provide evidence of a consensual and supportive CTO process.

5. **How do you get all of the provider’s signatures on the CTO?**

Ideally the CTO could be signed by all providers at a case conference. This may not be feasible due to timing or distance: some providers may be in a different community than where the CTO is being issued and the case conference held.

The use of FAX to obtain the required signatures is permissible. It is imperative that the CTO be legible. If faxing is necessary, it is recommended that the original CTO be faxed to each provider. Each provider will sign the treatment and care plan and return the signed document (may be by fax, original to follow by mail) to the issuing psychiatrist (or designated physician). DO NOT send the fax to one provider, have them sign and fax back and then “refax” to the next provider. This will result in an illegible document that is not acceptable to give to the patient or the review panel (if required).
6. **When it says “copies shall be given to” what does this mean? Who gets the original?**

Except for the written statement (Form 26) the original forms stay with issuer. The original must be produced if requested for by the review panel or Court of Queen's Bench for a hearing. See Appendix VII for detailed information about completing and distributing CTO forms.

7. **At what point does the CTO come into effect?**

The CTO is considered *issued* when two physicians (one of whom is a psychiatrist) have signed the order on Forms 19 or 20 – Parts I and II.

For a CTO to be *valid*, the two physicians must have each examined the person (separately) within 72 hours of signing / issuing, the CTO.

- A CTO cannot be issued until it is known that the treatment or care the person requires exists in the community, is available and will be provided (section 9.1(1)(d) of the Act).
- It is prudent for Parts I and II to be signed after all of the care providers have signed the treatment and care plan in Part III.
- A supervising physician must be identified (if this is not the issuing psychiatrist), and
- It must be determined whether a SDM is required (e.g. if the person is not competent).

In practical terms, this may mean that at least one physician will examine the person more than once. The first time will be to determine whether the person is suitable to be considered for a CTO. It may take some time - days or even weeks - to ensure all of the treatments listed on the order are available (e.g. no waiting lists) and will be provided, and all of the providers have been consulted, agree to and have signed the order. When all of these components are in place, it may be necessary for the physician(s) to re-examine the person to ensure the criteria is met within the 72 hour window of issuing the CTO.

All five parts of the form must be completed legibly, with all the necessary signatures for the form to be valid and the CTO to be “in effect”.

8. **How long is a CTO valid?**

The computation of time comes from *Alberta's Interpretation Act* – section 22(8). (See Chapter 3.10 of this guide for more detail.)

A CTO “expires 6 months after the day it was issued” unless it is renewed or cancelled. The key terms here are “months” and “after”. Rather than stipulating the number of days, the use of the term “month” allows for the variation in the length of each month. Use of the term “after” is understood to mean the next day.

For example, a CTO issued January 5 would expire July 6; a CTO issued August 30, 2010 would expire February 28, 2011. Note that 6 months plus a day would be the 31st; but February has only 28 days. Because section 22(8) (b) of the Act can be confusing, caution should be taken (and legal advice sought if necessary) when calculating the 6-month period.

The legislation states that a CTO may be renewed at any time before its expiry. This means a renewal must be completed PRIOR to the expiry of the existing order. As this can be done any time before the expiry of the current CTO, it is advised to begin this process well in advance, making specifics of the 6 month expiration less
of an issue and allowing time to ensure all of the criteria will be met, including the availability of the treatment and care.

9. **The Act frequently refers to the “issuing psychiatrist” in reference to CTOs. Is this the psychiatrist who first issued the original CTO?**

Not necessarily. The regulations define the “issuing psychiatrist” as the psychiatrist (or “designated physician” in accordance with section 9.7 of the Act), who last issued, renewed, or amended a CTO.

For the purpose of distributing copies of a CTO renewal, or amendment, and completing and distributing the written statement (Form 26) upon renewal or amendment, the “issuing psychiatrist” is the psychiatrist or “designated physician” who has just completed (e.g. issued), the renewal or amendment form.

10. **Who can supervise a CTO?**

The CTO must be supervised by a physician. This could be the issuing psychiatrist/designated physician or a psychiatrist or physician in the community.

It is expected that a CTO may often be initiated by a psychiatrist while the patient is in a designated facility as a formal patient. If the psychiatrist is not able to continue as the supervising physician, another community psychiatrist or physician will need to be identified, and agree to take on the supervisory role. This may occur when the patient is hospitalized in a different location than the community to which they will return upon discharge.

If the person supervising the CTO is not a psychiatrist or “designated physician”, he/she will not be able to amend, renew or cancel the CTO. Only a psychiatrist or “designated physician” may complete these processes and forms.

11. **Can a peace officer enter a person’s premises in order to apprehend that person when executing a CTO apprehension order (Form 23)?**

Yes. Section 9.6 of the Act – by way of Form 23: Community Treatment Order Apprehension Order explicitly gives peace officers authority to enter premises to apprehend individuals named in the form.

12. **Having conveyed a person identified in a CTO apprehension order or a judge’s warrant to a facility for examination, is a peace officer also required to complete a Form 10?**

No; duplicate forms are not required. Each one of these three processes, whether Form 8: Warrant (section 10(1)(1)), or Form 23: Community Treatment Order Apprehension Order (section 9(6)(1)), or Form 10: Statement of Peace Officer on Apprehension (pursuant to section 12(1)), gives a peace officer authority to apprehend and convey a person subject to, and believed non compliant with, a CTO to a facility for examination.

13. **What happens if the person not complying with a CTO is conveyed to a facility for examination on a weekend when the on-call physician may or may not be a psychiatrist?**

If a person not complying with a CTO is conveyed to a facility and arrives on the weekend when there may be only one physician on-call, he/she may have to wait until Monday for his/her second examination. The Act allows 72 hours for the examination to take place.

There is provision in the regulations that examinations may be conducted remotely using any means considered appropriate by the examining physician, including, but not limited to, video conference technology. Processes would need to be identified and established to determine who could be contacted remotely and when.
14. What role do “on-call” physicians play with CTOs?

Any psychiatrist can issue, renew, amend, cancel a CTO, or issue an apprehension order due to non-compliance.

In practice, the on-call psychiatrist would probably not have the extended period of time required to review a complex chart, interview the patient, write an opinion in the chart and complete the requisite forms. It is more likely that the second psychiatric opinion will be done over a period of a few days by a psychiatrist who is not on-call.

15. If an amendment is made to the CTO, does the whole order have to be re-written on Form 21, or can just the change be documented?

It is reasonable to interpret that it is only necessary to show the insertions and deletions (i.e. the changes), rather than reproduce the entire care plan on Form 21. That being said, it would be helpful if those filling out Form 21 include a statement that the person must still follow the treatment and care plan as outlined in the original CTO (Form 19) or the renewed CTO (Form 20) unless a particular requirement is expressly changed on Form 21.

16. What if there is an irregularity or insufficiency with respect to one of the Forms connected with a CTO?

Depending on the facts, there is the possibility that the form will be invalid; however section 52 of the Act provides that all forms issued under the Act, including those dealing with CTOs, shall not be held to be insufficient or invalid by reason only of any irregularity, informality or insufficiency in the form or in any proceedings in connection with the form.

17. How are treatment decisions made on behalf of minors subject to CTOs?

Section 28 of the Act creates a list of substitute decision-makers for minors subject to CTOs. That list should be consulted to determine the appropriate SDM. Notwithstanding section 28 of the Act, it may be possible to argue that a “mature minor” who is under a CTO can make their own mental health treatment decisions. Healthcare providers should contact their in-house legal counsel or Canadian Medical Protective Association as appropriate for legal advice in those circumstances.

18. Will patients with Fetal Alcohol Spectrum Disorder or Pervasive Developmental Disorders be eligible for CTOs?

If they meet all the criteria for CTOs, they may be considered for a CTO. Two of the criteria which may be of particular importance may be

- the treatment or care the person requires exists in the community, is available to the person and will be provided to the person,
- the person must be able to comply with the treatment or care requirements in the CTO.

19. Can outside agencies confirm with a regional health authority (e.g. AHS) whether a CTO is in place with respect to a particular patient?

This issue is governed by the Health Information Act (HIA). Whether or not a person is subject to a CTO is “health information”, and since a regional health authority is a custodian under HIA the health authority can only disclose this type of patient information if

- the patient has consented in accordance with section 34 of the HIA, or
- the disclosure falls within an exception listed in section 35 of the HIA.
Whether or not the disclosure can occur depends on *to whom the health authority is disclosing, and for what purpose.* It is recommended that regional health authorities (e.g. AHS) contact their Information and Privacy department with respect to disclosure in particular circumstances, since the answer will depend on the facts of each situation.

### 20. How can a person subject to a CTO contact the Office of the Mental Health Patient Advocate (the Advocate)?

**Web site:**  www.mhpab.ca/Contact/Pages/default.aspx

**Telephone:**  In Edmonton: 780 422-1812
Other Alberta: Toll-Free: 310-0000, then dial 780 422-1812

**In writing to:**  12th Floor, Centre West Building
10035-108 Street
Edmonton, AB. T5J 3E1

**E-mail:**  info@mhpab.ca
7.14 Flowchart and Key Points: Community Treatment Orders (CTO)
A. Definition of Mental Disorder (MHA 1(g))

A substantial disorder of thought, mood, perception, orientation, or behavior that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life.

E. Informing Patient and Others (see MHA 14)

Who* MHA 14(1)(b)
- Patient
- Patient’s substitute decision maker under s.28
- Physician responsible for supervising CTO
- Treatment Providers named in CTO

What MHA 14(1)(a)
- The reason for issuance of the CTO
- Authority for issuance of CTO
- Function of the Review Panel
- Notice of the right to apply for review panel hearing to appeal CTO
- Name and address of Review Panel Chair
- Notice of issuance, renewal, amendment, expiry or cancellation of CTO

How
- Written Statement (Form 26)
- Use verbal and written explanations
- Provide copy of CTO
- Use simple language
- An interpreter must be provided if necessary to facilitate understanding
- Give pamphlets about rights and copies of all certificates/documents to patients/SDM’s

*Additional notice to Family Doctor: on expiry or cancellation, along with any recommendations for treatment

F. Documentation

- Patient and Others’ receipt of:
  - CTO and Written Statement (Form 19 or 20 or 21 and Form 26)
  - Verbal and written information stating: reasons, duration, legal rights and date completed
- Patient’s awareness and apparent understanding of status and legal rights
- Response to information, behavior & mental status
- If an appeal is being made
- Patient’s consent or refusal of treatment

Not documented = Not done

G. Review Panel (see MHA 34-43)

- Composed of a chair or vice-chair (must be a lawyer), a psychiatrist, a physician, a member of the general public (see MHA 34-36)
- The applicant and the applicant’s representative have a right to be present during presentation of evidence
- Use Form 12 to apply for review panel hearing
- A board may apply on behalf of a person subject to CTO (MHA 3B(3))
- Any decision or order of the review panel may be appealed to the Court of Queen’s Bench

I. Mental Competency (see MHA 28)

Competency means that the person is able to understand the subject matter relating to, and the consequences of, making treatment decisions or giving consent and the consequences of not doing so.

Treatment decisions may be made on behalf of a person who is subject to a CTO, when they are a minor or are not mentally competent by (in the following priority order):
- (a) agent of the person (under personal directive)
- (b) guardian of the person on a CTO
- (c) nearest relative as defined in section 1(1)(i), or
- (d) the Public Guardian (last resort)

The authorized person shall make the treatment decisions in accordance with what they believe to be the best interests of the person on the CTO.

J. Criteria for CTO (MHA 9.1(1))

Two physicians, one of whom must be a psychiatrist, may, in accordance with the regulations, issue a CTO with respect to a person if they meet (a) to (f):

a. in their opinion, the person is suffering from a mental disorder, and
b. one or more of the following apply:
  i. within the immediately preceding three-year period the person has on two or more occasions, or for a total of at least 30 days:
     A. been a formal patient in a facility or
     B. been in an approved hospital or been lawfully detained in a custodial institution where there is evidence satisfactory to the two physicians that, while there, the person would have met the criteria (for a formal patient) as set out in paragraph 2(a) and (b) at that time or those times, or
     C. both been a formal patient in a facility and been in an approved hospital or lawfully detained in a custodial institution in the circumstances described in paragraph (B), or
  ii. the person has within the immediately preceding three-year period been subject to a community treatment order or
  iii. in the opinion of the two physicians, the person has, while living in the community, exhibited a pattern of recurrent or repetitive behavior that indicates that the person is likely to cause harm to the person or (i) or suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and
  iv. the two physicians, after separate examinations of the person by each of them within the immediately preceding 72 hours, are of the opinion that the person is likely to cause harm to the person or (i) or suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and
  v. the two physicians, after separate examinations of the person by each of them within the immediately preceding three-year period been subject to a community treatment order or
  vi. the person has, while living in the community, exhibited a history of not obtaining or continuing treatment or care that is necessary to prevent the likelihood of harm to others, and
  vii. the community treatment order is reasonable in the circumstances and would be less restrictive than retaining the person as a formal patient.

K. The CTO must: (see MHA 9.1(2)(3))

(a) Be written on the correct form (Form 19 or 20)
(b) Identify and be signed by the issuing physicians,
(c) Contain the dates and location (city/town & facility) of the examinations
(d) State the rationale/facts from which the issuing physicians formed their opinions
(e) Set out Treatment and Care and be signed by provider(s)*
(f) Identify and be signed by the physician responsible for supervising the CTO (Reg 3)
(g) Satisfy any other requirement provided for in the regulations.

* If the Treatment and Care Plan requires services provided by the regional health authority (AHS), ALL paperwork for CTO, amendments etc. must be signed by an AHS authorized person before it becomes effective. (CTO Reg 4)

L. Issuing a CTO

- “Issuing Psychiatrist” means the psychiatrist, or the “designated physician”, who last issued, renewed, or amended a CTO. (CTO Reg 1)
- If a psychiatrist is not available a physician may be "designated" under MHA 9.7(1). Designation is for maximum 2 years. Use Form 25 (CTO Reg 5).
- Examinations can be conducted remotely including by video conference (CTO Reg 2)
- It is recommended that the physician list a class of medication, the dosage, on the CTO
- Formal Patient Certificates are cancelled on the issuance of a CTO (MHA 9.1(3))

M. CTO Amendments, Renewals & Cancellation (see MHA 9.2-5)

- The issuing psychiatrist completes a Written Statement (Form 26) when issuing, renewing or amending a CTO (MHA 14(1.1)(a), CTO Reg 8(1))
- CTO is valid for 6 months and can be renewed anytime before its expiry (MHA 9.2.3)
- Issuing psychiatrist to send copy of renewal forms to review panel for deemed applications (CTO Reg 9(1))
- CTO can only be amended or cancelled by a psychiatrist or designated physician. (MHA 9.4, 9.5)
- If medication is stated by class on a CTO adjustments within the class do not require an amendment (Form 19 and 20 part III)
- An amendment to the Treatment and Care Plan must be on Form 21 with copy of CTO attached
- CTO supervisor issues notice of the cancellation or expiry of a CTO (CTO Reg 8(2))
- CTO should be cancelled upon admission as formal patient. (MHA 9.8(4))

N. CTO Non Compliance (see MHA 9.6)

- Within 24 hours of becoming aware, a Treatment or Care Provider(s) must report non compliance to regional health authority or to the AHS (Reg 6, Form 27)
- Before an apprehension order for non-compliance is issued, patient must be informed of the consequences of non compliance and assistance must be provided to help them comply with CTO (MHA 9.6)
- An order for apprehension under MHA 9.6 must be on Form 23 (Expires 30 days)
- Two examinations and decision to amend, cancel or continue CTO must be made within 72 hours of arrival at a facility (Form 24)

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<th>Form Name</th>
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Disclaimer: This document is intended as a guide and should not be used as a legal reference or advice. Please consult a lawyer if in need of clarification or legal advice. The information herein is not fully comprehensive; for complete details please refer to Alberta’s Mental Health Act and the accompanying regulations. AHS is not liable in any way for actions based on the use of information contained herein.

9/2/2010
This chapter will cover

- what is the intent of the *Health Information Act*,
- what is common terminology,
- who can access health information,
- when access to health information may be denied,
- when health information can be used and disclosed without patient consent,
- what considerations are given to minors’ requests to access health information,
- questions about access, use and disclosure of health information in practice.
8.1 Introduction to the Health Information Act (the “HIA”)

Given the personal and sensitive nature of psychiatric and mental health related information, the Mental Health Act provides numerous safeguards, largely noted in section 17. The Health Information Act’s provisions also apply.

Intent

The Health Information Act contains rules about the collection, use and disclosure of health information by “custodians”. The legislation’s intent is to

• protect the privacy of individuals and confidentiality of their health information,
• ensure that health information is appropriately shared and accessed,
• prescribe rules for the collection, use and disclosure of health information,
• make certain that health records are protected, and
• provide individuals with the right to access and make corrections to their own health information (with certain exceptions).

Terminology

Familiarity with the following terms in the Health Information Act helps those working in healthcare understand the parameters for using and disclosing health information in practice.

The term “custodian” in the Health Information Act (the HIA), includes, among others, regional health authorities and designated facilities (see Appendix II).

For example, currently there is only one regional health authority - Alberta Health Services (AHS).
AHS is a custodian under the HIA.

The term “affiliate” of a custodian is defined in the HIA and includes

• employees of the custodian,
• any person that performs services for the custodian (e.g. volunteer or student),
• health service providers who can admit and treat patients at hospitals (e.g. physicians with hospital privileges).

The term “disclosure” refers to giving health information by any means e.g. oral, written, copied, electronic, facsimile, telephone, data transfer on the internet, to any person or organization external to the custodian.

• includes sending health information from one custodian to another custodian or non-custodian, but
• does not include the sharing of information among affiliates of the same custodian.

Therefore, sharing of information among affiliates of AHS (as an example) is not considered “disclosure”; rather it is “use” of that information.
Principles

Relevant principles underlying the legislation that are referred to in the HIA Guidelines and Practices Manual include:

- custodians are the trusted “gatekeepers” of individuals’ health information. They must determine whether the amount and type of information to be collected, used and disclosed is necessary,
- custodians must have the necessary authority to collect, use or disclose the information,
- individuals (e.g. patients, minor patients in some cases, former patients, representatives of patients) have the right (subject to some exceptions) to access their own health information, to ask that it be corrected, and to know why it is being collected.

There are numerous rules for use and disclosure of electronic health information. Custodians must have technical and physical safeguards to protect all records and information. The Office of the Information and Privacy Commissioner (Alberta) is responsible for overseeing compliance with the Health Information Act.

8.2 The Right to Access Health Information

Section 104 of the HIA identifies who can have right of access to health information, e.g. the health record. For instance, access may be exercised by the following individuals or authorized representative(s)

- an individual 18 years or older,
- an individual under 18 years of age who understands the nature of the right or power and the consequences of exercising the right or power (note: mature minors likely fit this criteria, as may others who may not meet the full mature minor criteria but meet the criteria in this clause),
- the guardian of a minor when the minor does not understand the nature of the right or power and consequences of exercising the right or power,
- the adult patient’s guardian or trustee (if it relates to their powers under the Adult Guardianship and Trusteeship Act and proof of their right to Act is provided),
- the agent of an individual under the Personal Directives Act (if the personal directive so authorizes),
- the attorney named in an individual’s power of attorney if the exercise of the right or power relates to the powers and duties conferred by the power of attorney. Note: it is important to ensure that accessing the health record relates to the attorney’s exercise of a function in the power of attorney,
- if the individual is deceased, by the individual’s personal representative if the exercise of the right or power relates to the administration of the individual’s estate,
- the nearest relative of a formal patient under the Act to carry out obligations or exercise rights under the Act,
- by any person with the individual’s written authorization to Act on his or her behalf, e.g. legal counsel.

8.3 The Right to Refuse Access to Health Information

The relationship among the Mental Health Act and Regulations and Health Information Act and Regulations is complex, and a legal opinion should ideally be sought on interpretive matters.
Section 11 of the Health Information Act provides that a custodian may refuse to disclose health information to an applicant if disclosure could reasonably be expected to

- result in immediate and grave harm to the applicant's mental or physical health or safety,
- threaten the mental or physical health or safety of another individual, or
- pose a threat to public safety.

A custodian can also refuse to disclose health information to an applicant:

- if the disclosure could reasonably lead to identifying the person who provided health information to the custodian in confidence, and
- where it is appropriate that the name of the person who provided the information be kept confidential.

A custodian must refuse disclosure in certain circumstances. Two examples from section 11(2) of the HIA provide that disclosure must be refused:

(a) if the health information is about an individual other than the applicant, unless the health information was originally provided by the applicant in the context of a health service being provided to the applicant,

(b) if the health information sets out procedures or contains results of an investigation, a discipline proceeding, a practice review or an inspection relating to a health services provider.

8.4 Using and Disclosing Health Information in a Limited Manner

Custodians have a duty to use health information in a limited manner.

- That means they are required to use and disclose the least amount of information required for the custodian or recipient to carry out their intended purpose (section 58(1) of the HIA).

- Health information is to be shared internally on a 'need-to-know' basis (section 28 of the HIA).

With respect to disclosure, a custodian must consider the individual’s expressed wishes as a factor when deciding how much health information to disclose (section 58(2) of the HIA).

As an example, a formal patient in her seventh month of pregnancy is scheduled to attend an appointment with an obstetrician. The obstetrician has been following her throughout her pregnancy (prior to her hospital admission) and is well aware of her psychiatric history. The patient expresses concern about the confidential psychiatric information on her health record and whether it is necessary for the obstetrician’s team to have access to it. Taking into consideration the patient’s wishes and after discussion about ‘need-to-know’ information, it is agreed within the psychiatric team to share with the obstetrical team information relevant to the pregnancy and her current state of physical and mental health. Such information includes the patient’s medications, laboratory results, blood pressure readings, her response to current treatment and any concerns or risks. The amount of ‘need to know’ information changes with each patient. Depending on the patient’s mental illness, relevant mental health information may be disclosed if it affects her pregnancy.

8.5 Using and Disclosing Health Information without the Patient’s Consent

Though the following are not the only instances of use and disclosure of health information under the HIA, they are examples commonly encountered in practice. Healthcare providers are encouraged to refer to their facility’s or organization’s policies prior to the disclosure of patients’ health information.
Health services under same custodian

Subject to any rules set by the custodian, the custodian’s employees who are healthcare providers and the physicians on staff at the custodian’s facilities may share a patient’s health information among themselves, without the patient’s consent, if it is for the purpose of providing health services to that patient.

Continuing care and treatment

It is permissible to disclose diagnostic, treatment and care information without the individual’s consent to a person providing continuing care and treatment. This provision is not limited to healthcare providers (section 35(1)(b) of the HIA).

Permissible disclosure would include, for instance, a parent, relative, caregiver or friend involved in the ongoing care of a patient. It would also include a care provider from a sector outside of health who is providing continuing care and treatment.

Imminent danger

A provision in the HIA permits a custodian to disclose health information without consent to any person, including but not limited to police if the custodian believes, on reasonable grounds, that the disclosure will avert or minimize imminent danger to the health or safety of any person.

Three criteria must be satisfied for “imminent danger” to exist:

• clarity: the intended victim(s) are identifiable,
• danger: the danger to the victim must be serious bodily harm or death,
• imminence: the risk must be serious and a sense of urgency must be created by the threat of danger. The risk could be a future risk but must be serious enough that a reasonable person would believe that the harm would be carried out.

These three criteria must be considered in the context of each situation and in view of the surrounding circumstances. There must be a clear and imminent threat of serious bodily harm or death to an identifiable group or person that creates a sense of urgency (section 35(1)(m) of the HIA).

To protect public health and safety

A custodian has discretionary authority to disclose limited identifying health information without the individual’s consent to the police or the Minister of Justice and the Attorney General where the custodian reasonably believes

• the information relates to a possible commission of an offence under a statute of Alberta or Canada, and
• the disclosure will protect the health and safety of Albertans (section 37.3 HIA; this section number will soon change).

In this instance, if a healthcare provider employed by or contracted with AHS doesn’t want to disclose to the police and wants to disclose to the Minister, he/she can contact AHS Legal for information about who in the Ministry to contact. Otherwise the clinician can contact the Minister’s office to be directed to the appropriate person.

The limited amount of information that can be disclosed is as follows

(a) name of an individual,
(b) date of birth of an individual,
(c) nature of any injury or illness of an individual,
(d) date on which a health service was sought or received by an individual,
(e) location where an individual sought or received a health service,
(f) whether any samples of bodily substances were taken from an individual.

Disclosure to the medical examiner’s office

When a formal patient dies the medical examiner must be notified (Fatality Inquiries Act, sections 11(b), 12(b)).

In practice, if a formal patient dies in a facility, the medical examiner (ME) comes to the unit where the death occurred. As part of the ME’s investigation, the ME asks to view the current health record. If the death of the formal patient occurs outside the facility (e.g. while the patient is on pass) the ME is notified as soon as the patient’s death is reported to the facility. In this case, the ME also requests access to the health record. Furthermore, the ME can ask to review the health record of any mental health patient who died unexpectedly post discharge.

Health records can be disclosed to the MEs office pursuant to section 35(1)(p) of the HIA (authorizing disclosure without consent if the disclosure is authorized or required by an Act of Alberta or Canada) together with section 21(3) of the Fatality Inquiries Act which provides

(3) Notwithstanding any other Act, regulation or other law, a medical examiner is entitled to inspect and make copies of any diagnosis, record or information relating to

(a) a person receiving diagnostic and treatment services in a diagnostic and treatment centre under the Mental Health Act, or

(b) a patient under the Hospitals Act.

Special rules for disclosure to police by emergency medical services

Further, the Emergency Health Services Act provides for the disclosure of certain information by ambulance attendants to peace officers without consent of the patient. Such information includes but is not limited to the nature of a patient’s illness, which includes mental illness.

Special rules for disclosure of gunshot and stab wounds

The Gunshot and Stab Wound Mandatory Disclosure Act, effective April 1, 2010, mandates that staff working in healthcare facilities and emergency medical technicians report certain information to the local police service when a gunshot or stab wound is treated (or treatment is offered). Reporting is not required if staff or EMTs reasonably believe that the stab wound is self-inflicted or unintentionally inflicted. Reporting will include only limited patient information, e.g. patient’s name, the healthcare facility and type of wound but no treatment or diagnostic information. For more information on this legislation and the specified information that must be disclosed, health care providers are encouraged to contact their internal legal counsel.

Disclosure of information provisions in the Mental Health Act

Readers are encouraged to view section 17 of the Mental Health Act in its entirety for other situations where health information can be disclosed without patient consent (e.g. to the Public Guardian, Public Trustee, review panel, Director of Medical Services under the Occupational Health and Safety Act, the Workers’ Compensation Board, the Department of Health Canada, Review Board appointed pursuant to the Criminal Code (Canada), Council of College of Physicians and Surgeons of Alberta, a hearings director of a college under the Health Professions Act, the Health Disciplines board, etc.).
Notification of discharge

Provisions for notifying individuals of a patient’s discharge without patient consent are covered both in the Mental Health Act and the Health Information Act.

**Mental Health Act**

a) Section 32 – applies to all patients under the Act (including voluntary & formal patients)

- Notification of discharge is covered in Section 32 of the Act which states that, when reasonably possible, a patient’s nearest relative must be notified of his/her discharge if the patient does not object.

  As an example, this could apply when a voluntary patient discharges him/herself against medical advice if the patient had not previously voiced an objection.

- Similarly, when reasonably possible, the patient’s guardian is to be given notice of discharge. This would apply in all guardianship circumstances (e.g. the AGTA, guardians of minors under the Child, Youth and Family Enhancement Act, or parent guardians of minors).

- Another recently added provision in Section 32 of the Act requires notification of the family physician, if known, on a patient’s discharge. As well, a discharge summary and any recommendations for treatment are to be sent.

- With all notifications under section 32 of the Act, when applicable a statement shall be included regarding whether a certificate of incapacity issued under the Public Trustee Act exists with respect to the patient.

b) Section 17 – applies to all patients under the Act:

- When a patient is discharged from a facility for the purposes of transferring him/her to another treatment centre, hospital or nursing home, copies of the appropriate records of diagnostic and treatment services provided to that patient are forwarded for use at the receiving facility (section 17(9) of the Act).

**Health Information Act**

- Discharge notification may be disclosed to a caregiver who is involved in the continuing care of the patient (section 35(1)(b) of the HIA).

  For instance, an aunt who drives her nephew to a clinic for bi-weekly mental health follow-up may be advised of the patient’s discharge. A worker in a Group Home could be notified of a patient’s date of discharge and return to that facility.

8.6 Disclosure of Health Information with Consent

A person’s health information can also be disclosed with their consent. Their consent must meet the requirements set out in section 34 of the HIA. Healthcare providers are encouraged to refer to their applicable policies and use their organization’s standard consent form.
1. **What information is disclosed to the family physician on a patient’s discharge?**

Section 32 of the Act directs that, when reasonably possible, notice of the patient’s discharge must be provided to the family doctor, including a discharge summary and any recommendations for treatment. Additionally, when applicable, the discharge information is to identify whether a Certificate of Incapacity (issued under the Public Trustee Act) exists with respect to the patient.

(Note: all the existing Certificates of Incapacity formerly issued under the Dependent Adults Act were transferred to the Public Trustee Act in October of 2009 when the Dependent Adults Act was repealed.)

The Act does not require the patient’s consent in this instance. Some clinicians advise the patient that a discharge summary is being sent to his/her family physician though notifying the patient is not a requirement under the Act.

2. **What if a patient specifically instructs his/her physician not to send discharge notice and follow-up information to the family physician?**

It is a requirement under the law for the discharge notice, discharge summary, and recommendations for treatment (and when applicable the identification of whether a Certificate of Incapacity is in effect under the Public Trustee Act) to be sent to the family physician where reasonably possible. Therefore, this information must be sent even if it is against a patient’s wishes. The healthcare team would be encouraged to speak with the patient to explore the reasoning behind his/her request.

3. **Can formal patients view their current health record?**

Yes, patients have right of access by completing a written request unless the exceptions set out in section 11 of the Health Information Act apply. For instance, under section 11(1)(a) access to the record would be denied if it would result in immediate and grave harm to the applicant’s mental or physical health or safety, threaten the mental or physical health or safety of another individual, or pose a threat to public safety. (sections 11(1) and 11(2) of the Act are set out in the guide section 8.3.)

Readers with questions are encouraged to contact their organization’s Information and Privacy department, and reference their organization's policies.

4. **How should healthcare providers respond when a formal patient asks to read their current health record?**

In practice, if the patient asks staff about reading his/her chart, it is helpful if staff inform the attending physician of the patient’s request so the physician and patient can discuss it.

Questions may arise relative to the applicant’s mental competency. The guardian or substitute decision-maker may not consider it is in the best interests of the formal patient to access their health information.

Affiliates should contact the Information and Privacy department at their facility for clarification of the patient's rights in these situations or indeed, when any concerns or uncertainty exist (e.g. about information on the health record that may be detrimental to the patient or another person).

Many physicians prefer to be with the patient at the time of reading health information in order to explain any entries or language that is not understood and to answer any questions that arise.
5. **Can patients under the age of 18 (including formal minors, minors who are subject to CTOs, voluntary minors and mature minors) request access to their health record?**

It depends. Minors (whether formal or not) can exercise their own rights under HIA if they understand the nature of the right and the consequences of exercising that right.

In order to determine whether a person under the age of 18 is a mature minor capable of understanding the nature and consequences of exercising his/her rights or powers under HIA, the following factors must be regarded:

- the individual’s age,
- maturity,
- independence,
- level of understanding, and
- the nature and complexity of the HIA rights or powers.

The Privacy Commissioner ruled that the level of understanding that is required for an individual to understand the nature and consequences of exercising rights or powers under HIA is not a particularly onerous standard (OIPC Order F2005-017 and H2005-001).

If the minor does not understand the nature of his/her rights & consequences under HIA, then his/her guardian can exercise those rights (section 104(1)(c)).

If healthcare providers need guidance whether a mature minor under the Act can expressly preclude his/her guardian from obtaining the patient’s health information, they should seek guidance from their organization’s internal legal counsel.

6. **Can staff and physicians answer questions from family or friends about the diagnosis and treatment of formal patients?**

- The Health Information Act provides that so long as disclosure is not contrary to the patient’s expressed wishes, the custodian may provide limited information without the patient’s consent. Information such as the patient’s location, diagnosis, progress, prognosis and condition on that day may be disclosed to persons in a close personal relationship with the patient. “Close personal relationship” could include common-law spouse, friend or person who can demonstrate he/she has such a relationship with the patient (section 35(1)(c) of the HIA).

  For example, if a patient said to her physician, “I don’t want you to tell my sister anything about my diagnosis”, the physician would not disclose that health information to the named relative.

- Section 14(1) of the Mental Health Act addresses disclosing information as well. For instance, formal patients are asked upon notification of certification and rights for their consent to have a nearest relative and one other person notified of the person’s certification and any applications to review panels.

- There are also circumstances in which regular communication is expected of the team and is allowed. This is the case in disclosure of information to guardians of formal and voluntary patients - whether they are guardians under the Adult Guardianship and Trusteeship Act or guardians/parents of minor patients.

- Similarly, the team can engage in treatment-related communication with agents and substitute decision-makers under section 28 of the Mental Health Act.

  In general, if a healthcare provider is uncertain about the patient’s wishes, it is good practice to inform the competent patient about the information request and ask the patient for their consent. Some patients may stipulate conditions. They may ask, as is their right, that specific information
not be discussed with an identified person. (This expressed wish would be granted provided the
identified person is not the patient’s substitute decision-maker under section 28 of the Act.)

If a healthcare provider is concerned about conflict, or unsure about disclosure or refraining from disclosing health
information, they are encouraged to seek legal advice from their organization’s internal legal counsel or Canadian
Medical Protective Association as appropriate.

7. **What should healthcare providers do when they are uncertain whether or not they can call
the police, how much information they can tell the police, and whether they have a duty to
call the police.**

Healthcare providers are encouraged to consult their organization’s legal counsel (e.g. AHS Legal Services)
or Information and Privacy department if they need guidance regarding 1) whether they have an obligation
to disclose given the particular circumstances and 2) how much information to disclose.

Readers can review the comprehensive 2007 Alberta Health and Wellness *Health Information Act - Guidelines and
This chapter will cover

- what is the jurisdiction of the Advocate,
- whose complaints the Advocate can investigate,
- what the Advocate can investigate without a complaint,
- what rights advice is given,
- who investigates complaints,
- what are the notification requirements,
- when the Advocate may refuse to investigate,
- how an investigation is conducted,
- what information does the facility provide the Advocate,
- how confidentiality is maintained during the investigation,
- who receives the report at the end of an investigation,
- how to contact the Advocate,
- questions about the Mental Health Patient Advocate in practice.
Introduction

Sections 44 through 47 of the Act together with the Patient Advocate Regulation under the Act provide for the Lieutenant Governor in Council to appoint a Mental Health Patient Advocate (the Advocate) to Act as an investigative body.

The Advocate is independent from the entities that are subject to investigation, and reports directly to the Minister of Health and Wellness (section 47 of the Act, and section 7(3) of the Patient Advocate Regulation).

The Patient Advocate Regulation defines a “patient” as a person who

a) is or has been a formal patient,

b) is or has been subject to one admission certificate or renewal certificate,

c) is or has been subject to a community treatment order.

In this chapter nine, the term “patient” will have the same meaning as in the regulation.

9.1 Jurisdiction

The Advocate is the only provincial investigative body created specifically to deal with complaints from or relating to persons detained in designated facilities under one or two admission or renewal certificates, and persons subject to CTOs.

The Advocate’s roles and responsibilities are found in section 45 of the Act together with the Patient Advocate Regulation. The Advocate is specifically authorized to conduct an investigation with or without a complaint, and provide rights advice.

9.2 Investigations Based on Complaints

The Advocate has jurisdiction to investigate complaints regarding

- patients under one admission certificate or one renewal certificate,
- formal patients (patients under two admission certificates, or renewal certificates), and
- persons who are subject to CTOs.

The Advocate does not have the jurisdiction to investigate complaints regarding voluntary patients. Section 3(4) of the Patient Advocate Regulation limits the Advocate’s investigation to the period during which the person was subject to one or two admission certificates, one or two renewal certificates, or a CTO.

If, for example, the Advocate received a complaint following the discharge of a previously formal patient, the investigation could encompass the time from the issuance of the first admission certificate through to the cancellation or expiration of the last two admission or renewal certificates issued on the patient during that hospitalization.
9.3 Investigations without a Complaint

Without receiving a complaint, section 4 of the Patient Advocate Regulation enables the Advocate to investigate

- any procedure relating to the admission of a person detained in a facility pursuant to the Act,
- any procedure for 1) informing a patient of his/her rights, and 2) providing information as required by the Act to a patient and to guardians, nearest relatives or designates of a patient, and
- any procedure of a regional health authority or an issuing psychiatrist relating to the issuance, amendment or renewal of a CTO.

9.4 Rights Advice

After receiving a complaint, section 3(5) of the Patient Advocate Regulation requires that the Advocate provide to the patient and the complainant, as far as is reasonable, information about

- the patient's rights under the Act,
- how the patient may obtain legal counsel,
- how the patient may apply to the review panel,
- how the patient can commence an appeal to the Court of Queen's Bench.

9.5 Investigation of Complaints

A complaint may be investigated by the Advocate or an employee of the Mental Health Patient Advocate Office. Employees may be appointed to assist the Advocate (section 48(1) of the Act). The Advocate may in writing delegate to any person any power or duty under the Act or the Patient Advocate Regulation, except for the power or duty to make a report (section 2 of the Patient Advocate Regulation).

The Advocate conducts formal and informal investigations. Most concerns brought to the attention of the Advocate are resolved through informal investigation and mediation.

Formal investigations are conducted into issues that cannot be easily resolved. These could include allegations about abuse or events that happened many years ago, when the patient had formal status. Only the Advocate may order a formal investigation. The distinction between the conduct of the two types of investigations is outlined in the Advocate’s 2007/2008 Annual Report available at: www.mpha.ab.ca.

9.6 Notification Requirements

Section 3(1) of the Patient Advocate Regulation provides that, after receiving a complaint from or relating to a patient, the Advocate must

- notify the board of the facility where the patient is or was detained of the nature of the complaint,
- notify the patient in writing that a complaint has been received, the nature of the complaint, and any investigation arising from the complaint, and
- if an individual other than the patient is named in a complaint, notify the individual of any investigation arising.
In addition, section 5(1) of the Patient Advocate Regulation requires that

- the Advocate notify the board of the facility of the Advocate's intention to contact a patient of the facility, and
- the Advocate must notify the regional health authority or issuing psychiatrist of the Advocate's intent to investigate an issue that relates to that regional health authority or psychiatrist.

### 9.7 Refusal to Investigate

The Advocate may refuse to investigate or cease to investigate a complaint if the Advocate believes that the subject matter of the complaint is trivial, the complaint is frivolous or vexatious, or if the Advocate believes that no investigation is necessary (section 8 of the Patient Advocate Regulation).

### 9.8 Conduct of Investigation

The Advocate has discretion about how to conduct the investigation (section 5(1)(b) of the Patient Advocate Regulation).

- The Advocate may make any inquiries that the Advocate considers necessary.
- The Advocate is authorized to make any contact with the patient and conduct any investigation of the complaint the Advocate considers necessary (section 3(1)(d) of the Patient Advocate Regulation).
- The Advocate is not required to hold a hearing (section 5(3) of the Patient Advocate Regulation).

### 9.9 Conduct of Investigation; Right to Make Representations

The patient and the person who have been named in a complaint and have received notification of an investigation have the right to make representations to the Advocate (section 3(3) of the Patient Advocate Regulation).

### 9.10 Conduct of Investigation; Cooperation by the Facility

Upon request, a facility, board, regional health authority or issuing psychiatrist must provide to the Advocate within a reasonable time (section 5(4) of the Patient Advocate Regulation)

- any of their policies or directives or other documents relating to an investigation, and
- any medical or other record or any information, file or other document relating to a patient who is the subject of an investigation.

Upon request, the facility must provide copies of any of these materials (section 5(5) of the Patient Advocate Regulation). This request expires 3 months after the date on which it is made (section 45(3) of the Act).

If the board is notified of the Advocate's intention to contact a patient, the board must grant the Advocate access at all reasonable times (section 5(2) of the Patient Advocate Regulation).

### 9.11 Confidentiality of Information Obtained During the Investigation

The Advocate must not disclose information obtained during an investigation except as required by law or in the performance of the Advocate's duties under the Act or Regulation (section 6 of the Patient Advocate Regulation).
9.12 Record of Investigation

The Advocate must maintain a record of every complaint and investigation (section 5(1) of the Patient Advocate Regulation).

9.13 Reporting at the End of a Formal Investigation

- The Advocate must provide the board, regional health authority, or issuing psychiatrist with a copy of the Advocate’s investigation report (section 7(1) of the Patient Advocate Regulation).
- If the report contains recommendations, it must state the reasons for the recommendations (section 7(2) of the Patient Advocate Regulation).
- Should the Advocate believe that the board, regional health authority, or issuing psychiatrist has not taken appropriate action within a reasonable time on any recommendation, the Advocate must send a copy of the report and any response to the Minister of Health and Wellness (section 7(3) of the Patient Advocate Regulation).
- The Advocate must inform a patient of the disposition of any complaint (section 9(a) of the Patient Advocate Regulation).
- The Advocate may inform a complainant of the disposition of any complaint they initiate (section 9(b) of the Patient Advocate Regulation).

9.14 Contact Information

The Mental Health Patient Advocate can be contacted as follows:

The telephone number in Edmonton is 780-422-1812. This number can be accessed outside Edmonton toll-free at 310-0000 then dial 780-422-1812. A confidential answering machine is available to those who call outside of the office hours.

The office is open from 8:15 a.m. to 4:30 p.m. from Monday through Friday, and is closed over the noon hour.

The address is 12th Floor, Center West Building, 10035 - 108 Street, Edmonton, Alberta T5J 3E1

The Advocate’s website is www.mhpa.ab.ca.
9.15 Questions about the Mental Health Patient Advocate in Practice

1. **Do complaints to the Advocate have to be written or be in any particular form?**

   Complaints and concerns may be communicated by phone, email, in writing by mail, or in person by visiting the Advocate’s office in Edmonton.

2. **Within what time frame must the facility provide information to the Advocate?**

   The Act states that copies of materials requested must be provided to the Patient Advocate within a ‘reasonable time’. The Advocate provides timelines in the written notification letter advising the facility to supply the Advocate with the required information.

   In addition, timelines for response to any recommendations are outlined in the report of the investigation to the board of the facility. The written response to the Advocate’s recommendations must meet the timelines. Should a recommendation require more time to implement than that given, the Advocate should be advised of progress made at the time of the written response.

3. **Can the Advocate, when investigating facility procedures, access health records and interview formal patients if no complaint has been received?**

   Yes, if accessing the health records and/or interviewing the formal patient relates to the Advocate’s investigation. The Advocate has broad discretion and can make inquiries that the Advocate considers necessary to conduct an investigation. (See sections 5(1), (2) and (4) of the Patient Advocate Regulation.)

4(a). A family physician issues a Form 1 admission certificate on a patient who is taken to hospital for examination. The patient subsequently lodges a complaint with the Advocate. Can the Advocate, in the course of an investigation, ask for information from the issuing family physician?

   Yes.

   **If so, what information can be accessed?**

   The Advocate is designated as a “custodian” under the Health Information Act (section 2 Health Information Regulation). Health information can be disclosed by the family physician to the Advocate pursuant to sections 35(1)(a) and 27(1)(f) of the HIA. The patient’s consent is not required. However, only the information necessary to enable the Advocate to carry out the intended purpose should be disclosed (section 58 of the HIA).

   (Note: section 5(4) of the Patient Advocate Regulation does not apply since the issuing family physician is not a facility, board, regional health authority, or “issuing psychiatrist” as defined in that regulation.)

4(b). **What if the patient’s parent, rather than the patient, asked the Advocate to look into the admission of their son as a formal patient?**

   The answer is the same as in question 4(a) above.
Appendix I: Flowcharts and Key Points
Person shows signs of a mental disorder (A) and certification is being considered

- Person may access MH Patient Advocate services at any time after first Form 1
- Review Panel hearing may be requested anytime once person is a Formal Patient
- Automatic Review Panel Hearing 6 months after admission or since last review

Physically available for examination by physician?

YES

Examined by a physician

NO

Meet ALL 3 criteria? (C)

Within 24 hours of exam physician issues an Admission Certificate (Form 1) (D)

Meet ALL 3 criteria? (C)

Examined by a physician on staff at facility within 24 hours of arrival at facility

NO

NO

Examines to control patient to prevent serious bodily harm are allowed (H)

YES

Consider CTO

NO

Seek Judge’s Warrant (Form 8) (Expiry 7 days)

OR

Peace Officer’s Statement (Form 10) (B)

NO

Meet ALL 3 criteria? (C)

Discharge

YES

Willing to accept treatment in facility?

NO

Patient or Other applies for Review Panel to challenge certification

YES

Review Panel Hearing: within 21 days (G)

NO

Continues as Formal Patient

Each renewal: 2 physicians must complete separate exams and Renewal Certificates (Form 2), at least one must be a psychiatrist and one a facility staff physician

1st renewal: 1 month
2nd renewal: 1 month
3rd and subsequent renewals: 6 months
If not renewed Formal status expires

Meets ALL 3 criteria? (C)

For additional information refer to Formal Patient Competency & Consent for Treatment Decisions

Interventions

While waiting for Hearing, objects to treatment?

YES

Review Panel decision to continue Formal status?

NO

Continues as Formal Patient

NO

Formal Certificates cancelled

Contd as a voluntary patient or discharge

YES

Consider CTO

NO

Apprehend and convey to facility

If not renewed Formal status expires

Within 24 hours of exam physician issues an Admission Certificate (Form 1) (D)
### A. Definition of Mental Disorder

(see MHA 1(9))

A substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life.

### B. Apprehension by Warrant or Peace Officers Statement (see MHA 10 and 12)

To apprehend a person to conduct an examination, the Judge and/or the Peace Officer must have reasonable and probable grounds to believe that the person is in a condition likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment and:

- Judges Warrant: (section 10, Form 8)
  - There is no other way to arrange for an examination.
  - Application supported by sworn information that the person is suffering from mental disorder
- Peace Officer: (section 12, Form 10)
  - The person is suffering from a mental disorder
  - The person should be examined for their own safety or the safety of others.
  - Circumstances are such that proceeding under section 10 would be dangerous

### C. Three Criteria for Formal Patient Certification (see MHA 2(a-c))

- Suffering from a mental disorder
- In a condition likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment
- Unsuitable for admission to a facility other than as a formal patient

### D. Admission Certificates

#### Effect of One Admission Certificate (see MHA 4(1))

Gives sufficient authority to:
- Care for, observe, assess, detain and control, apprehend and convey to a facility within 72 hours of issue
- Care for, observe, assess, detain and control the person during apprehension and conveyance
- Care for, observe, examine, assess, treat, detain and control the person for up to a maximum of 24 hours after arrival at facility unless a 2nd certificate is written

#### Effect of Two Admission Certificates (see MHA 7(1,2))

Gives sufficient authority to:
- Care for, observe, examine, assess, treat, detain and control the person named on the certificate for up to one month after issuing of the certificates
- One certificate must be signed by a physician on staff at the facility
- If needed, Renewal Certificates must be completed prior to expiry of existing certificates

### E. Informing Patient and Others (see MHA 14)

- **Who**
  - Patient
  - Patient’s agent, substitute decision maker (SDM)
  - Patient’s nearest relative (unless patient objects)
  - Patient may designate one person s. 14 (1) & (4)

#### What
- The reason for issuance of the certificates
- The authority for detention and the period of it
- Function of the review panel
- Notice of the right to apply for a review panel hearing to appeal treatment orders, certificates or finding of incompetence

### F. Documentation

- Patient’s and Others’ receipt of:
  - Certificates
  - Verbal and written information about formal status: reasons, duration and legal rights, date completed
- Patient’s awareness and apparent understanding of formal status and legal rights
- Response to information, behavior & mental status
- If an appeal is being made
- Patient’s consent or refusal of treatment

Not documented = Not done

### G. Review Panel (see MHA 34-43)

- Composed of a chair or vice-chair (must be a lawyer), a psychiatrist, a physician, a member of the general public (see MHA 34-36). Review panel members may not be on staff at the facility and must not be treating or have treated the patient.
- The applicant and the applicant’s representative have a right to be present during presentation of evidence
- Use Form 12 to apply for review panel hearing
- A board (usually delegated to a physician) may apply on behalf of a formal patient (MHA 38(2))
- A board or attending physician may apply to review panel for treatment order (MHA 29(2))
- Any decision or order of the review panel may be appealed to the Court of Queen’s Bench

### H. Control (see MHA 30)

Control is the minimal use of reasonable force, by mechanical means or medication - without patient’s consent – as necessary to prevent serious bodily harm to the person or another person.

If interventions / medications, are used to control the behavior, not to treat patient, staff must document behavior requiring control and measures used.

### I. Mental Competency (see MHA 28)

Competency means that the person is able to understand the subject-matter relating to, and the consequences of, making treatment decisions or giving consent & the consequences of not doing so.

Treatment decisions may be made on behalf of a formal patient when the patient is a minor or is not mentally competent by (in the following priority order):

- (a) agent of the patient (under personal directive)
- (b) guardian of the patient
- (c) nearest relative as defined in section 1(1)(l), or
- (d) the Public Guardian (last resort)

The authorized person shall make the treatment decisions in accordance with what they believe to be the best interests of the patient.

### Additional Information

- Formal Patient Certificates (admission / renewal) are cancelled on the issuance of a Community Treatment Order. (MHA 9.1(3))
- On admission as a formal patient, the Community Treatment Order should be cancelled (MHA 9.6(4c))
- Mental Health Patient Advocate services available at any time

<table>
<thead>
<tr>
<th>#</th>
<th>Form Name</th>
<th>Completed by</th>
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<tbody>
<tr>
<td>1</td>
<td>Admission Certificate</td>
<td>2 Physicians</td>
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<td>2</td>
<td>Renewal Certificate</td>
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<td>3</td>
<td>Order to Return a Formal Patient to a Facility</td>
<td>Board’s Delegate e.g. Physician</td>
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<td>Minister of Health and Wellness or designate</td>
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<td>Memorandum of Transfer to Another Facility</td>
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<td>10</td>
<td>Statement of Peace Officer on Apprehension</td>
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<td>11</td>
<td>Certificate of Incompetence to Make Treatment Decisions</td>
<td>A) Physician &amp; B) Rep of Facility Board, usually a Physician</td>
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<td>12</td>
<td>Application for Review Panel Hearing</td>
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<td>Decision of Review Panel Regarding Mental Incompetence to Make Treatment Decisions</td>
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<td>18</td>
<td>Decision of Review Panel Regarding Renewal Certificates &amp; CTO’s (Deemed Application)</td>
<td>Review Panel Chair</td>
</tr>
</tbody>
</table>
Person becomes a Formal Patient

Competent to make treatment decisions? (I)

YES

NO

Physician completes Certificate of Incompetence (Form 11) - Notification & Copies given to patient and others

Review of Form 11 requested?

YES

NO

Substitute decision maker identified (I)

Substitute decision maker agrees to treatment?

YES

NO

Patient objects to treatment?

YES

NO

Second physician agrees patient is incompetent?

YES

NO

Second physician examines patient

SDM is patient’s agent or nearest relative?

YES

NO

Physician may apply to Review Panel Hearing for Treatment Order (Form 12)

Treatment Order Hearing within 7 days (G) Until decision made, treatment that the patient/SDM objects to is not given. Interventions to control patient to prevent serious bodily harm are permitted (H)

Treatment Order issued?

YES

NO

Interventions only to control patient to prevent serious bodily harm (H)

Treatment given

• Review Panel decisions can be appealed to the Court of Queens Bench

• Patient may access Patient Advocate services at any time after 1st Certificate

Competency hearing within 7 days. Until decision made by review panel, the physician’s opinion of incompetence may not be acted upon. Interventions to control patient to prevent serious bodily harm are permitted (H)
Formal Patient Competency and Consent - Key Points

**A. Definition of Mental Disorder** *(see MHA 1(g))*

A substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life.

**B. Apprehension by Warrant or Peace Officers Statement** *(see MHA 10 and 12)*

To apprehend a person to conduct an examination, the Judge and/or the Peace Officer must have reasonable and probable grounds to believe that the person is in a condition likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment and:

- Judges Warrant: (section 10, Form 8)
  - There is no other way to arrange for an examination.
  - Application supported by sworn information that the person is suffering from mental disorder.
- Peace Officer: (section 12, Form 10)
  - The person is suffering from a mental disorder
  - The person should be examined for their own safety or the safety of others.
  - Circumstances are such that proceeding under section 10 would be dangerous.

**C. Three Criteria for Formal Patient Certification** *(see MHA 2(a-c))*

- Suffering from a mental disorder
- In a condition likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment
- Unsuitable for admission to a facility other than as a formal patient

**D. Admission Certificates**

**Effect of One Admission Certificate** *(see MHA 4(1))*

Gives sufficient authority to:
- Care for, observe, assess, detain and control, apprehend and convey to a facility within 72 hours of issue.
- Care for, observe, assess, detain and control the person during apprehension and conveyance.
- Care for, observe, examine, assess, treat, detain and control the person for up to a maximum of 24 hours after arrival at facility unless a 2nd certificate is written.

**Effect of Two Admission Certificates** *(see MHA 7(1,2))*

Gives sufficient authority to:
- Care for, observe, examine, assess, treat, detain and control the person named on the certificate for up to one month after issuing of the certificates.
- One certificate must be signed by a physician on staff at the facility.
- If needed, Renewal Certificates must be completed prior to expiry of existing certificates.

**E. Informing Patient and Others** *(see MHA 14)*

Who*
- Patient
- Patient’s agent, substitute decision maker (SDM)
- Patient’s nearest relative (unless patient objects)
- Patient may designate one person s. 14 (1) & (4)

What
- The reason for issuance of the certificates.
- The authority for detention and the period of it
- Function of the review panel
- Notice of the right to apply for a review panel hearing to appeal treatment orders, certificates or finding of incompetence

How
- Provide copies of certificates
- Use verbal and written explanations
- Use simple language
- An interpreter must be provided if necessary to facilitate understanding
- Provide pamphlets about rights and copies of all documents to patient / SDM’s

* Additional notice to Family Doctor - upon discharge, along with discharge summary including recommendations for treatment

**F. Documentation**

- Patient’s and Others’ receipt of:
  - Certificates
  - Verbal and written information about formal status, reasons, duration and legal rights, date completed
- Patient’s awareness and apparent understanding of formal status and legal rights
- Response to information, behavior & mental status
- If an appeal is being made
- Patient’s consent or refusal of treatment

Not documented = Not done

**G. Review Panel** *(see MHA 34-43)*

- Composed of a chair or vice-chair (must be a lawyer), a psychiatrist, a physician, a member of the general public (see MHA 34-36).
- Review panel members may not be on staff at the facility and must not be treating or have treated the patient.
- The applicant and the applicant’s representative have a right to be present during presentation of evidence.
- Use Form 12 to apply for review panel hearing.
- A board (usually delegated to a physician) may apply on behalf of a formal patient (MHA 38(2)).
- A board or attending physician may apply to the review panel for treatment order (MHA 29 (2)).
- Any decision or order of the review panel may be appealed to the Queen’s Bench.

**H. Control** *(see MHA 30)*

Control is the minimal use of reasonable force, by mechanical means or medication - without patient’s consent – as necessary to prevent serious bodily harm to the person or another person.

If interventions / medications, are used to control the behavior, not to treat patient, staff must document behavior requiring control and measures used.

**I. Mental Competency** *(see MHA 28)*

Competency means that the person is able to understand the subject-matter relating to, and the consequences of, making treatment decisions or giving consent & the consequences of not doing so.

Treatment decisions may be made on behalf of a formal patient when the patient is a minor or is not mentally competent by (in the following priority order):
- (a) agent of the patient (under personal directive)
- (b) guardian of the patient
- (c) nearest relative as defined in section 1(i), or
- (d) the Public Guardian (last resort)

The authorized person shall make the treatment decisions in accordance with what they believe to be the best interests of the patient.

**Additional Information**

- Formal Patient Certificates (admission / renewal) are cancelled on the issuance of a Community Treatment Order. (MHA 9.1(3))
- On admission as a formal patient, the Community Treatment Order should be cancelled (MHA 9.6(4c))
- Mental Health Patient Advocate services available at any time

<table>
<thead>
<tr>
<th>#</th>
<th>Form Name</th>
<th>Completed by</th>
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<tbody>
<tr>
<td>1</td>
<td>Admission Certificate</td>
<td>2 Physicians</td>
</tr>
<tr>
<td>2</td>
<td>Renewal Certificate</td>
<td>1 Physician 1 Psychiatrist</td>
</tr>
<tr>
<td>3</td>
<td>Order to Return a Formal Patient to a Facility</td>
<td>Board’s Delegate e.g. Physician</td>
</tr>
<tr>
<td>4</td>
<td>Certificate of Transfer into Alberta</td>
<td>Minister of Health and Wellness or designate</td>
</tr>
<tr>
<td>5</td>
<td>Transfer of Formal Patient to a Facility Outside Alberta</td>
<td>Minister of Health and Wellness or designate</td>
</tr>
<tr>
<td>6</td>
<td>Memorandum of Transfer to Another Facility</td>
<td>Board’s Delegate e.g. Physician, at sending facility</td>
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<tr>
<td>7</td>
<td>Information</td>
<td>Informant</td>
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<td>8</td>
<td>Warrant</td>
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<td>Extension of Warrant</td>
<td>Judge</td>
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<tr>
<td>10</td>
<td>Statement of Peace Officer on Apprehension</td>
<td>Peace Officer</td>
</tr>
<tr>
<td>11</td>
<td>Certificate of Incompetence to Make Treatment Decisions</td>
<td>A) Physician &amp; B) Rep of Facility Board, usually a Physician</td>
</tr>
<tr>
<td>12</td>
<td>Application for Review Panel Hearing</td>
<td>Patient / SDM / Board / Anyone</td>
</tr>
<tr>
<td>13</td>
<td>Notice of Hearing Before Review Panel</td>
<td>Review Panel Chair</td>
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<td>14</td>
<td>Decision of Review Panel Regarding Mental Incompetence to Make Treatment Decisions</td>
<td>Review Panel Chair</td>
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<td>Decision of Review Panel Regarding Treatment</td>
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<td>16</td>
<td>Decision of Review Panel regarding Transfer back to a Correctional Facility</td>
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<td>17</td>
<td>Decision of Review Panel Regarding Admission Certificates, Renewal Certificates or CTO's (Deemed Application)</td>
<td>Review Panel Chair</td>
</tr>
<tr>
<td>18</td>
<td>Decision of Review Panel Regarding Renewal Certificates</td>
<td>Review Panel Chair</td>
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</table>

**Disclaimer:** This document is intended as a guide and should not be used as a legal reference or advice. Please consult a lawyer if in need of clarification or legal advice. The information herein is not fully comprehensive; for complete details please refer to Alberta’s Mental Health Act and the accompanying regulations. AHS is not liable in any way for actions based on the use of information contained herein.

8/27/2010
### A. Definition of Mental Disorder (MHA 1(g))

A substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life.

### E. Informing Patients and Others (see MHA 14)

**Who** MHA 14(1)(b) (b)

- Patient
- Patient's substitute decision maker under s.28
- Patient may designate one person (s. 14(1) & (4))
- Physician responsible for supervising CTO

**Treatment Providers named in CTO**

- What MHA 14(1)(a)
  - The reason for issuance of the CTO
  - Authority for issuance of CTO
  - Board of the Review Panel
  - Notice of the right to apply for review panel hearing to appeal CTO

- Name and address of Review Panel Chair
- Notice of issuance, renewal, amendment, expiry or cancellation of CTO

**How**

- Written Statement (Form 26)
- Use verbal and written explanations
- Provide copy of CTO
- Use simple language
- An interpreter must be provided if necessary to facilitate understanding

- Give pamphlets about rights and copies of all certificates / documents to patients / SDM's

- *Additional notice to Family Doctor - on expiry or cancellation, along with any recommendations for treatment*

### F. Documentation

- Patient’s and Others’ receipt of:
  - CTO and Written Statement (Form 19 or 20 or 21 and Form 26)
  - Verbal and written information stating: reasons, duration, legal rights and date completed

- Patient’s awareness and apparent understanding of status and legal rights

- Response to information, behavior & mental status

- If an appeal is being made

- Patient’s consent or refusal of treatment

Not documented = Not done

### G. Review Panel (see MHA 34-43)

- Composed of a chair or vice-chair (must be a lawyer), a psychiatrist, a physician, a member of the general public (MHA 34 3B)

- The applicant and the applicant’s representative have a right to be present during presentation of evidence

- Use Form 12 to apply for review panel hearing

- A board may apply on behalf of a person subject to CTO (MHA 38(2))

- Any decision or order of the review panel may be appealed to the Court of Queen’s Bench

### I. Mental Competency (see MHA 28)

Competency means that the person is able to understand the subject matter relating to, and the consequences of, making treatment decisions or giving consent and the consequences of not doing so.

Treatment decisions may be made on behalf of a person who is subject to a CTO, when they are a minor or are not mentally competent by (in the following priority order):

- a. agent of the person (under personal directive)
- b. guardian of the person on a CTO
- c. nearest relative as defined in section 1(1)(i), or (ii)
- d. the Public Guardian (last resort)

The authorized person shall make the treatment decisions in accordance with what they believe to be the best interests of the person on the CTO.

### J. Criteria for CTO (MHA 9.1(1))

Two physicians, one of whom must be a psychiatrist, in accordance with the regulations, issue a CTO with respect to a person if they meet (a) to (f):

- a. in their opinion, the person is suffering from a mental disorder, and
- b. one or more of the following apply:
  - i. within the immediate preceding three-year period the person has on two or more occasions, or for a total of at least 30 days, A. been a formal patient in a facility or B. been in an approved hospital or been lawfully detained in a custodial institution where there is evidence satisfactory to the two physicians that, while there, the person would have met the criteria (for a formal patient) as set out in section 2(a) and (b) at that time or those times, or
  - C. both been a formal patient in a facility and been in an approved hospital or lawfully detained in a custodial situation in the circumstances described in paragraph (B); or
- ii. the person has within the immediately preceding three-year period been subject to a community treatment order or
- iii. in the opinion of the two physicians, the person has, while living in the community, exhibited a pattern of repetitive or repetitive behavior that indicates that the person is likely to cause harm to the person or others or suffer substantial mental or physical deterioration or serious physical impairment and the person does not receive continuing treatment or care while living in the community, and
- c. the two physicians, after separate examinations of the person by each of them within the immediately preceding 72 hours, are both of the opinion that the person is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and
- d. the treatment or care the person requires exists in the community, is available to the person, and will be provided to the person, and
- e. in the opinion of each physician, the person is able to comply with the treatment or care requirements set out in the community treatment order, and
- f. either:
  - i. consent to the issuing of the community treatment order has been obtained, A. if the person is competent, from the person, or B. if the person is not competent, in accordance with section 28(1), or
  - ii. consent to the issuing of the community treatment order has not been obtained but in the opinion of the issuing physician, A. the person has, while living in the community, exhibited a history of not obtaining or continuing with treatment or care that is necessary to prevent the likelihood of harm to others, and
  - B. a community treatment order is reasonable in the circumstances and would be less restrictive than retaining the person as a formal patient.

### K. The CTO must:

- Be written on the correct form (Form 19 or 20)
- Identify and be signed by the issuing physicians,
- Contain the dates and location (city/town & facility) of the examinations
- State the rationale/ facts from which the issuing physicians formed their opinions
- Set Out Treatment and Care and be signed by provider(s) *
- Identify and be signed by the physician responsible for supervising the CTO (Reg 3)
- Satisfy any other requirement provided for in the regulations

* If the Treatment and Care Plan requires services provided by the regional health authority (AHS), all paperwork for CTO, amendments etc. must be signed by an AHS authorized person before it becomes effective. (CTO Reg 4)

### L. Issuing a CTO

- "Issuing Psychiatrist" means the psychiatrist, or the "designated physician", who last issued, renewed, or amended a CTO (CTO Reg 1)
- If a psychiatrist is not available a physician may be "designated" under MHA 9.7(1). Designation is for maximum 2 years. Use Form 25 (CTO Reg 5).
- Examinations can be conducted remotely including by video conference (CTO Reg 2)
- It is recommended that the physician list a class of medication, not the dosage, on the CTO
- Formal Patient Certificates are cancelled on the issuance of a CTO (MHA 9.1(3))

### M. CTO Amendments, Renewals & Cancellation (see MHA 9.2-5)

- The issuing psychiatrist completes a Written Statement (Form 26) when issuing, renewing or amending a CTO (MHA 14.1(1)(a), CTO Reg 8(1))
- CTO is valid for 6 months and can be renewed anytime before its expiry (MHA 9.2.3)
- Issuance psychiatrist to send copy of renewal forms to review panel for deemed applications (CTO Reg 9(1))
- CTO can only be amended or cancelled by a psychiatrist or designated physician. (MHA 9.4, 9.5)
- If medication is stated on a CTO: adjustments within the class do not require an amendment (Form 19 and 20 part III)
- An amendment to the Treatment and Care Plan must be on Form 21 with copy of CTO attached
- CTO supervisor issues notice of cancellation or expiry of a CTO (CTO Reg 8(2))
- CTO should be cancelled upon admission as formal patient. (MHA 9.6(4)(c))

### N. CTO Non Compliance (see MHA 9.6)

- Within 24 hours of becoming aware, a Treatment or Care Provider must report non compliance to regional health authority (AHS) (Reg 6, Form 27)
- Before an Apprehension Order for non-compliance is issued, patient must be informed of the consequences of non compliance and assistance must be provided to help them comply (MHA 9.6)
- An order for apprehension under MHA 9.6 must be on Form 23 (Expires 30 days)
- Two examinations and decision to amend, cancel or continue CTO must be made within 72 hours of arrival at a facility (Form 24)

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<tr>
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<td>Issuance of CTO</td>
<td>Psychiatrist &amp; Physician</td>
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<td>20</td>
<td>Renewal of CTO</td>
<td>Psychiatrist &amp; Physician</td>
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<td>21</td>
<td>Amendments to CTO</td>
<td>A Psychiatrist</td>
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<tr>
<td>22</td>
<td>CTO Cancellation or Expiry</td>
<td>A Psychiatrist or &quot;Designated Physician&quot;</td>
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<tr>
<td>23</td>
<td>CTO Apprehension Order</td>
<td>Psychiatrist</td>
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<td>24</td>
<td>CTO Examination on Apprehension</td>
<td>Psychiatrist &amp; Physician</td>
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<td>25</td>
<td>CTO Designation of Physician</td>
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<td>26</td>
<td>Written Statement</td>
<td>Issuing Psychiatrist</td>
</tr>
<tr>
<td>27</td>
<td>CTO Non-compliance Report</td>
<td>Treatment or Care Provider</td>
</tr>
</tbody>
</table>
Glossary

Glossary contains only key terms found in this guide.

**ACT**

In this guide the “Act” means the *Mental Health Act* (Alberta)

**ADMISSION CERTIFICATE**

A certificate issued under section 2 or 3 of the *Act* by an examining physician who believes a person is

- suffering from a mental disorder,
- likely to cause harm to that person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and
- unsuitable for admission to a facility other than as a formal patient (section 1(a) of the *Act*).

An admission certificate may also be issued under section 3 for a person detained under the *Criminal Code of Canada* or *Youth Criminal Justice Act* (of Canada).

**AGENT**

This term is defined under the *Personal Directives Act* (Revised Statutes of Alberta 2000, section 1(a)) as an individual with the authority to make personal decisions for a person who completes a personal directive.

These decisions may involve health-care matters, including examinations, procedures, services or treatments completed for therapeutic, preventive, palliative, diagnostic or other purposes.

The *Personal Directives Act* is available at the Government of Alberta, Queen’s Printer, Laws Online Results website: www.qp.alberta.ca/Laws_online.cfm. Once on the website, search by title for the *Personal Directives Act*.

**COMMUNITY TREATMENT ORDER**

An order issued by two physicians (one of whom must be a psychiatrist) if a person meets certain criteria and the physicians believe the person will experience recurring relapses and hospitalizations (frequently as formal patients under the *Act*) if the person does not receive the required community treatment or care.

**CORRECTIONAL INSTITUTION**

In the *Corrections Act*:

“(i) a holding or lock up facility operated by the police on a daily fee or a fee for service basis for the purpose of confining persons being held in custody prior to court appearances, on remand or undergoing a sentence or sentences of imprisonment either imposed by a court in Alberta, or imposed elsewhere than in Alberta when those persons are transferred to Alberta pursuant to an act of Canada or an act of another province or territory,

(ii) a detention or remand facility operated by or for the Government of Alberta to detain arrested, charged or convicted persons pursuant to a law in force in Alberta,

(iii) a forestry or similar facility operated by the Government of Alberta,
(iv) a jail or institution referred to in section 6(1), or

(v) any other facility designated as a correctional institution by the Minister but does not include a secure services facility within the meaning of the Child, Youth and Family Enhancement Act.”

The Mental Health Act refers to a Correctional Facility (section 33 of the Act) and a Custodial Institution (section 9 of the Act, dealing with CTOs), rather than a Correctional Institution. A Custodial Institution likely has a more broad meaning than a Correctional Facility. For example, an open custody group home for youth may be a ‘custodial institution’ but not a correctional facility.

FACILITY

“A place or part of a place designated in the regulations as a facility” (section 1(d) of the Act). In practice the term refers to inpatient health facilities which have been authorized by the Lieutenant Governor in Council as the only hospitals which can admit and detain formal or involuntary patients under the Mental Health Act.

There are many hospitals in Alberta but only a limited number are designated facilities under the Mental Health Regulation. A list of these facilities as of October 2009 is in Appendix III (section 1(1) of the Mental Health Regulation 19/2004).

FORMAL PATIENT

“A patient detained in a facility pursuant to two admission certificates (section 2 and 3 of the Act) or two renewal certificates (sections 8 and 9 of the Act).”

GUARDIAN

Under the Mental Health Act

• the parent or guardian of a minor,

• a director as defined in the Child, Youth and Family Enhancement Act for a child who is subject to a temporary or permanent guardianship order,

• a guardian appointed under the Adult Guardianship and Trustee Act who has the authority to
  • commence, compromise or settle any legal proceeding that does not relate to the estate of the dependent adult,
  • consent to any health care that is in the dependent adult’s best interests

Under the Adult Guardianship and Trustee Act

• An individual appointed by a Court to make decisions for a dependent adult, acting in the best interests of the dependent adult, whose interests will not conflict with the dependent adult’s interests.

• A Guardian is appointed under the Adult Guardianship and Trustee Act where the Court is satisfied that an adult is repeatedly and continuously unable to care for themselves, and to make reasonable judgments.

• Usually among the Guardian’s powers and authorities is the power to consent to any health care that is in the dependent adult’s best interests.

• The Adult Guardianship and Trustee Act and its Regulations are located at the Government of Alberta, Queen’s Printer, Laws Online Results website: www.qp.alberta.ca/Laws_online.cfm. Complete a search by title: Adult Guardianship and Trustee Act.
MENTAL DISORDER

A substantial disorder of thought, mood, perception, orientation or memory that grossly impairs

• judgment,
• behaviour,
• capacity to recognize reality, or
• ability to meet the ordinary demands of life (section 1(g) of the Act).

NEAREST RELATIVE

For a formal patient or a person subject to a community treatment order - in descending priority order, the person’s

• spouse or adult interdependent partner,
• son or daughter,
• father or mother,
• brother or sister,
• grandfather or grandmother,
• grandson or granddaughter,
• uncle or aunt,
• nephew or niece

(Refer to section 1(1)(i)(ii) of the Mental Health Act for more information if there is no person within the above description, or the person determined as above would not or is not acting in the best interest of the formal patient or person subject to a CTO.)

PATIENT

In the Mental Health Act, “patient” means a person who is admitted to a facility as an inpatient or as an outpatient for diagnosis or treatment services, or both.

In this guide, the term “patient” is primarily used as defined in the Act. It is however, also used more broadly at times e.g. to refer to persons subject to community treatment orders. The meaning of the word “patient” will depend on the context.

PERSONAL DIRECTIVE

Advanced personal instructions regarding personal matters as defined in the Personal Directives Act (section 1(k) and Part 2).

The website reference is located at the Government of Alberta, Queen’s Printer, Laws Online Results: www.qp.alberta.ca/Laws_online.cfm. Complete a search by title: Personal Directives Act.
PUBLIC GUARDIAN

The person appointed as the Public Guardian pursuant to the Adult Guardianship and Trustee Act.

Under section 107 of the Adult Guardianship and Trustee Act, the Public Guardian means a Provincial Government staff member appointed to attend to the circumstances of persons needing a guardian, where no individuals are willing, able and suitable.

REGIONAL HEALTH AUTHORITY

An organization created pursuant to the Regional Health Authorities Act and subsequent Ministerial Orders. Alberta Health Services derives its authority from this legislation.

A copy of this act can be found on the Government of Alberta, Queen’s Printer, Laws Online Results website: www.qp.alberta.ca/Laws_online.cfm. Complete a search by title: Regional Health Authorities Act.

RENEWAL CERTIFICATE

A certificate issued pursuant to section 8 (section 1(o) of the Act). This provides a mechanism for extending a formal patient's period of detention, after two physicians who have separately examined a formal patient, believe that formal patient requires continuing psychiatric care.

REVIEW PANEL

A four member panel established pursuant to section 34 of the Act to hear the following applications

- to review a certificate of incompetence to make treatment decisions, signed by a physician (section 27 of the Act),
- from a physician for a treatment order (section 29 of the Act),
- to transfer a person back to a correctional centre (section 33 of the Act),
- to review/cancel admission certificates or renewal certificates (section 38 of the Act),
- to cancel a CTO (section 38(1.1) of the Act)

SUBSTITUTE DECISION-MAKER (SDM)

A person who makes treatment decisions on behalf of a person who is a formal patient or is subject to a CTO, when they are a minor or are not mentally competent. The Act (section 28) specifies who may be a SDM.

VOLUNTARY PATIENT

A “voluntary patient” in the mental health context usually refers to a patient who is admitted to a facility of their own volition for the purpose of receiving mental health diagnosis or treatment.

For the purpose of this guide, included in this category are patients who are admitted for mental health diagnosis or treatment in a facility by way of the consent of a substitute decision-maker (e.g. guardian). In other materials, these individuals are sometimes referred to as “informal patients”. Regardless of their categorization, they are not detained under admission or renewal certificates, and thus in this manual are treated as “voluntary”.

132  Guide to the Alberta Mental Health Act and Community Treatment Order Legislation  ■  September 2010
Appendix III: List of Designated Facilities (October 2010)
List of Designated Facilities (October 2010)

1(1) The following places are designated as facilities for the purposes of section 1(d) of the Mental Health Act:

(a) Alberta Hospital Edmonton
(b) Centennial Centre for Mental Health and Brain Injury (Ponoka)
(c) Peter Lougheed Centre (Calgary)
(d) Foothills Medical Centre (Calgary)
(e) Misericordia Community Hospital (Edmonton)
(f) Royal Alexandra Hospital (Edmonton)
(g) University of Alberta Hospital (Edmonton)
(h) Grey Nuns Community Hospital (Edmonton)
(i) Chinook Regional Hospital (Lethbridge)
(j) Medicine Hat Regional Hospital
(k) Northern Lights Regional Health Centre (Fort McMurray)
(l) Queen Elizabeth II Hospital (Grande Prairie)
(m) Rockyview General Hospital (Calgary)
(n) Claresholm Centre for Mental Health and Addictions
(o) Red Deer Regional Hospital Centre
(p) Southern Alberta Forensic Psychiatry Centre (Calgary)
(q) St. Therese, St. Paul Health Care Centre
(r) Villa Caritas (Edmonton)

(2) The following places are designated as facilities for the purposes of section 13 of the Act:

(a) Northern Alberta Forensic Psychiatry Centre of the Alberta Hospital Edmonton
(b) Southern Alberta Forensic Psychiatry Centre (Calgary)
Appendix IV: Mental Health Act Forms
Electronic versions of all the Mental Health Act forms are available on the Alberta Health Services website at www.albertahealthservices.ca/1256.asp. These forms can be a) completed on the computer and then printed and signed, or b) printed then completed by hand and signed. They may not be altered in any way.

Form 1: Admission Certificate (section 2 of the Act)
Form 2: Renewal Certificate (section 8 of the Act)
Form 3: Order to Return a Formal Patient to a Facility (sections 20(4) or 21(1) of the Act)
Form 4: Certificate of Transfer into Alberta (section 24(1) of the Act)
Form 5: Transfer of Formal Patient to a Jurisdiction Outside Alberta (section 25 of the Act)
Form 6: Memorandum of Transfer to Another Facility (section 22(1) of the Act)
Form 7: Information (section 10 of the Act)
Form 8: Warrant (section 10 of the Act)
Form 9: Extension of Warrant (section 11 of the Act)
Form 10: Statement of Peace Officer on Apprehension (section 12 of the Act)
Form 11: Certificate of Incompetence to Make Treatment Decisions (section 27 of the Act)
Form 12: Application For Review Panel Hearing (sections 27(3), 29(2), 33, 38(1) and 38(1.1) of the Act)
Form 13: Notice of Hearing Before Review Panel (section 40 of the Act)
Form 14: Decision of Review Panel Regarding Mental Incompetence to Make Treatment Decisions (sections 27(3) and 41 of the Act)
Form 15: Decision of Review Panel Regarding Treatment (sections 29(2) and 41 of the Act)
Form 16: Decision of Review Panel Regarding Transfer Back to a Correctional Facility (sections 33 and 41 of the Act)
Form 17: Decision of a Review Panel Regarding Admission Certificates, Renewal Certificates, or Community Treatment Orders (sections 38(1), 38(1.1) and 41 of the Act)
Form 18: Decision by a Review Panel Regarding Renewal Certificates and Community Treatment Orders (Deemed Application) (sections 39 and 41 of the Act)
Form 19: Issuance Community Treatment Order (section 9.1 of the Act)
Form 20: Renewal of Community Treatment Order (section 9.3 of the Act)
Form 21: Amendments to Community Treatment Order (section 9.4 of the Act)
Form 22: Community Treatment Order, Cancellation or Expiry (section 9.5 of the Act)
Form 23: Community Treatment Order, Apprehension Order (section 9.6 of the Act)
Form 24: Community Treatment Order, Examination on Apprehension (section 9.6 of the Act)
Form 25: Community Treatment Order, Designation of Physician (section 9.7 of the Act)
Form 26: Community Treatment Order, Written Statement (section 14(1.1)(a) of the Act)
Form 27: Community Treatment Order, Non-compliance Report (section 9.1(2)(f) of the Act)
I _______________ (print name of physician) of __________________________ (address) certify that I personally examined __________________________ (print name of person examined) of __________________________ (home address) on _______________ (date) at _______________ (time) at __________________________ (place of examination)

In my opinion the person examined is
(a) suffering from mental disorder,
(b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and
(c) unsuitable for admission to a facility other than as a formal patient.

I have formed my opinion
(a) on the following facts observed by me:

(b) on the following facts communicated to me by others:

Place an “X” in the box if conveyance is required.

The person is not in a facility and is to be conveyed for examination to

__________________________ (name of facility)
at __________________________ (address of facility)

__________________________ (date of issue) _________________ (time of issue)

__________________________ (signature of physician) __________________________ (printed name of physician)

Note: Section 1(g) of the Act reads:
(g) “mental disorder” means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs
(i) judgment, (ii) behaviour, (iii) capacity to recognize reality, or (iv) ability to meet the ordinary demands of life.
I, ___________________________ of ________________________________,

certify that I personally examined ________________________________

on ______________________________, at ____________ separately from any other physician.

In my opinion the person examined is
(a) suffering from mental disorder,  
(b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and  
(c) unsuitable to continue at a facility other than as a formal patient.

I have formed my opinion
(a) on the following facts observed by me:

(b) on the following facts communicated to me by others:

The person was examined at ________________________________

(date of issue) ________________________________ (time of issue)

(signature of physician) ________________________________  (printed name of physician)

Note: Sections 1(g) and 8(2) of the Act read:
1(g) “mental disorder” means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs  
(i) judgment,  (iii) capacity to recognize reality, or  
(ii) behaviour,  (iv) ability to meet the ordinary demands of life;

8(2) At least one of the physicians who issue renewal certificates under this section shall be a member of the staff of the facility at which the formal patient is detained and at least one of the certificates shall be issued by a psychiatrist.
To all or any peace officers in Alberta:

(a name of formal patient)

a formal patient, is absent without leave pursuant to the Mental Health Act.

You are hereby ordered to return the formal patient to

(a name of facility)

(adress of facility)

Admission certificates (or renewal certificates) expire on ____________________________.

(dated this ____________________________ day of ____________________________, 20__

(signature of representative of board of facility) (printed name of representative)

Note: Section 21(3) of the Act reads:

(3) A person who is returned to a facility under this section or section 20 may 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, if the certificates relating to that person expired during the period the person was absent from the facility, the person is deemed to be a person in respect of whom one admission certificate is issued when the person is apprehended by a peace officer under this section or section 20.
I have reasonable and probable grounds to believe that

(full name of person)

may come or be brought into Alberta and is

(a) suffering from mental disorder,
(b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and
(c) unsuitable for admission to a facility other than as a formal patient.

Pursuant to Section 24(1) of the Mental Health Act, I authorize a peace officer or

(name of person authorized)

to apprehend and convey

(full name of person)

to a facility for examination.

(date of issue)

(signature of the Minister of Health and Wellness or person designated by the Minister of Health and Wellness)  
(printed name of Minister of Health and Wellness or designated person)

Note: Section 1(g) of the Act reads:
(g) “mental disorder” means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs
(i) judgment,  
(ii) behaviour,  
(iii) capacity to recognize reality, or  
(iv) ability to meet the ordinary demands of life.
It appears to me

Choose one

☐ that ____________________________,

(name of formal patient)

has come or been brought into Alberta and that his/her care and treatment is the responsibility of

__________________________________________.

(name of other jurisdiction)

OR

☐ that it would be in the best interests of ____________________________,

(name of formal patient)

to be cared for in ____________________________________________.

(name of other jurisdiction)

Therefore, I authorize that ____________________________,

(name of formal patient)

be transferred to ____________________________________________.

(name of other jurisdiction)

__________________________________________

(date of issue)

__________________________________________  ____________________________________________

(signature of the Minister of Health and Wellness or person designated by the Minister of Health and Wellness)  (printed name of Minister of Health and Wellness or designated person)
Memorandum of Transfer to Another Facility (Form 6)

Mental Health Act Section 22(1)

Arrangements have been made with the board of

__________________________________________________________
(name of facility to which the patient is to be transferred)

to transfer

__________________________________________________________
(name of formal patient)

a formal patient in

__________________________________________________________
(name of facility in which patient is presently detained)

to

__________________________________________________________
(name of facility to which the patient is to be transferred)

Dated this __________________ day of __________________ , 20__.

(day) (month)

________________________ ____________________________
(signature of representative of board of sending facility) (printed name of representative)

Note: Section 22(2) of the Act reads:

(2) When a formal patient is transferred under subsection (1), the authority conferred by any certificates relating to the patient continues in force in the facility to which the patient is transferred.
This is the information of ________________________________ (name of informant) of ________________________________ (address of informant) who say that he/she has reasonable and probable grounds to believe that

______________________________ (name of person) of ________________________________ (address of person)
suffering from mental disorder, and likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, or

is subject to a community treatment order and is not complying with the order.

Sworn before me at the ________________
of ________________________________,
in the Province of Alberta, the _______ day of
_______________, 20____.

______________________________ (signature of informant) ________________________________ (printed name of informant)

Note: Section 1(g) of the Act reads:
(g) “mental disorder” means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs

(i) judgment, (iii) capacity to recognize reality, or
(ii) behaviour, (iv) ability to meet the ordinary demands of life.
To all or any peace officers in Alberta:

_______________________________ has brought before me an information on oath that

(name of informant)

_______________________________ of

(name of person)

_______________________________

(address of person)

☐ is suffering from mental disorder, and likely to cause harm to the person
or others or to suffer substantial mental or physical deterioration or
serious physical impairment, or

☐ is subject to a community treatment order and is not complying with the
order.

I am satisfied that ________________________________

(name of person)

☐ is suffering from mental disorder, and likely to cause harm to the person
or others or to suffer substantial mental or physical deterioration or
serious physical impairment, or

☐ is subject to a community treatment order and is not complying with the
order.

and that an examination can be arranged in no way other than by apprehension.

This is to order you to apprehend ________________________________ and convey

(name of person)

him/her to a facility for an examination.

Brief reasons:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Form 8  
Warrant  
Mental Health Act  
Section 10

Note: Section 1(g) and 10(7) of the Act reads: 

1(g) "mental disorder" means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs  
(i) judgment, (ii) behaviour, (iii) capacity to recognize reality, or (iv) ability to meet the ordinary demands of life.

10(7) Where a peace officer has not apprehended a person within 7 days of the date of the warrant, the warrant ceases to be effective unless, before the expiry of the 7-day period, a provincial judge extends the duration of the warrant under section 11.
To all or any peace officers in Alberta:

_________________________ issued a warrant dated_________________________.

(name of Judge of The Provincial Court of Alberta)

to apprehend ________________________________

(name of person)

The warrant has not been executed.

_________________________ ,                           of ________________________________,

(name of peace officer) (badge no.) (detachment)

☐ has appeared before me to apply for an extension of the warrant; or

☐ has applied for an extension of the warrant by telephone or other means of telecommunication, and it appears

on the oath of ________________________________ that it is impracticable to

(name of peace officer)

appear before me personally and that there are reasonable grounds for dispensing with any information

presented personally and in writing.

This order therefore extends the duration of the warrant for a period of 7 days from the day on which the warrant expires.

Dated at ________________________________ on the __________ day of ________________________________.

(place) (day) (month)

20____ at __________.

(time)

_________________________ (signature of Judge of The Provincial Court of Alberta)

(printed name of Judge of The Provincial Court of Alberta)

_________________________ (clerk of the Court) (date of filing)

Note: Section 11(1) and (6) of the Act reads:

11(1) On the application of a peace officer, a provincial judge may extend the duration of a warrant issued
under section 10 on one occasion only for a period of up to 7 days from the day on which the warrant
expires under that section.

11(6) A provincial judge who is satisfied that an application made by telephone or other means of
telecommunication

(a) conforms to the requirements of subsection (5), and

(b) discloses reasonable grounds for dispensing with personal appearance for the purpose of
making an application under subsection (1)

may make an order extending the duration of the warrant for a period of up to 7 days from the day on
which the warrant expires under section 10.
MH1986 (2010/01)

Statement of Peace Officer on Apprehension (Form 10)

Mental Health Act Section 12

_________________________________________ was apprehended on __________ at __________.

(name of person apprehended if known) (date) (time)

He/She was apprehended at

(describe place and address)

I have reasonable and probable grounds to believe that
(a) the person apprehended is suffering from mental disorder,
(b) the person apprehended is

☐ likely to cause harm to the person or others or to suffer substantial mental or
  physical deterioration or serious physical impairment,
  or

☐ subject to a community treatment order and is not complying with the order,

(c) the person apprehended should be examined in the interests of his/her own safety or the
  safety of others, and

(d) the circumstances are such that to proceed under section 10 of the Mental Health Act would
  be dangerous.

The grounds for my belief are:


Dated this __________

(day) (month) (year)

_________________________________________  ________________________________________

(signature of peace officer) (printed name of peace officer)

_________________________________________  ________________________________________

(badge number) (detachment)

Note: Sections 1(g) of the Act read:
1(g) “mental disorder” means a substantial disorder of thought, mood, perception, orientation or
memory that grossly impairs

(i) judgment,  (iii) capacity to recognize reality, or

(ii) behaviour,  (iv) ability to meet the ordinary demands of life.
Certificate of Incompetence to Make Treatment Decisions (Form 11)

Mental Health Act Section 27

Part One - To be completed by a physician.

I, __________________________, am of the opinion that

______________________________, is not mentally competent to make treatment decisions.

The reasons for my opinion are as follows:

(name of physician)

(name of formal patient)

Dated this ______________ day of ______________, 20__.

(name of physician) (printed name of physician)

Note: Section 26 of the Act reads:

(26) For the purposes of this Part, a person is mentally competent to make treatment decisions if he/she is able to understand the subject matter relating to the decisions and able to appreciate the consequences of making the decisions.

Part Two - To be completed by the board of a facility.

To:

______________________________, of

______________________________, (name of formal patient)

______________________________, (address)

And:

______________________________, of

______________________________, (name of patient’s guardian or agent, if any)

______________________________, (address)

And:

______________________________, of

______________________________, (name of nearest relative, unless patient objects)

______________________________, (address)

Take notice that ____________________________,

(name of formal patient)

is entitled to have the physician’s opinion about his/her competence to make treatment decisions reviewed by a review panel by sending to the chair of the review panel an Application for Review Panel Hearing, in Form 12.

Dated this ______________ day of ______________, 20__.

(signature of representative of board of facility) (printed name of representative)
Application for Review Panel Hearing (Form 12)

Mental Health Act Sections 27(3), 29(2), 33 and 38(1) and (1.1)

To: _______________________________________________________,
   (print name of chair of the review panel)

__________________________________________________________,
   (address of chair)

I, _______________________________________________________,
   (printed name of applicant)

of _____________________________________________________,
   (printed address of applicant)

bearing the relationship of ________________________________
   (self, relative, guardian, agent, physician, other)

to _____________________________________________________,
   (name of patient or person who is subject to a community treatment order)

☐ under section 27(3) of the Act for a review of the attached Certificate of Incompetence to
   Make Treatment Decisions, dated ____________________________

and signed by ____________________________________________ .

☐ under section 29(2) of the Act for an order directing that the following treatment
   be administered to ________________________________________.

   (nature of treatment)

   (Name of formal patient)

☐ under section 33 of the Act for an order transferring ____________________________
   back to ____________________________ .

   (name of patient)

   (name of correctional facility)

☐ under section 38(1) of the Act for cancellation of admission certificates or renewal
   certificates issued on ____________________________ .

☐ under section 38(1.1) of the Act for cancellation of the community treatment order
   ________________________________________________ on ____________________________ .

   (issued/amended/renewed)

   (date of issue/amendment/renewal)

Dated this ____________________ day of ____________________ , 20____.
   (signature of applicant)

Note:
Choose one and place an “X” in the appropriate box.

Note:
Place a circle around applicable wording.

I (do) (do not) object to my nearest relative being informed of the review panel hearings.

__________________________________________________________
   (signature of patient or person who is subject to community treatment order)

__________________________________________________________
   (printed name of patient or person who is subject to community treatment order)
Application received by the review panel ____________________________ (date)

Take notice that a hearing will be held

☐ under section 27(3) of the Act for a review of the physician’s opinion in the attached Certificate of Incompetence to Make Treatment Decisions relating to ____________________________ (name of formal patient)
dated ____________________________ and signed by ____________________________.

☐ under section 29(2) of the Act, for an order directing that the following treatment may be administered to ____________________________ (name of formal patient).

☐ under section 33 of the Act, for an order transferring ____________________________ (name of patient) back to a correctional facility.

☐ under section 38(1) of the Act, for cancellation of admission certificates or renewal certificates relating to ____________________________ (name of formal patient).

☐ under section 38(1.1) of the Act for cancellation of community treatment order ____________________________ on ____________________________ (issued/amended/renewed) (date of issue/amendment/renewal).

☐ under section 39 of the Act for

☐ cancellation of renewal certificates relating to ____________________________ (name of formal patient)
or

☐ cancellation of the community treatment order relating to ____________________________ (name of person who is subject to the community treatment order).

The review panel will hear the application on ____________________________ at ____________________________ at ____________________________ (date) (time)

______________________________ (place)

______________________________ (date of issue) ____________________________ (signature of chair of review panel) ____________________________ (printed name of chair)

______________________________ (address)
Decision of Review Panel Regarding Mental Incompetence to Make Treatment Decisions (Form 14)

Mental Health Act Sections 27(3) and 41

Note:
Choose one and place an “X” in the appropriate box.

The formal patient (does) (does not) object to the nearest relative,

____________________________________________________________________________________

(name of nearest relative),

receiving notice of the decision.

The review panel has heard and considered the application of ______________________________________________________________________

(name of formal patient) and has decided

☐ to cancel the attached Certificate of Incompetence to Make Treatment Decisions dated ________________

and signed by ____________________________________________________________________________.

☐ to refuse to cancel the Certificate of Incompetence to Make Treatment Decisions dated ________________

and signed by ____________________________________________________________________________.

Date of decision __________________________________________________________________________.

(signature of chair of review panel)  (printed name of chair)

This decision may be appealed to the Court of Queen’s Bench within 14 days after receipt of this decision.
The formal patient (does) (does not) object to the nearest relative,

__________________________________________________________ ,

(name of nearest relative)

receiving notice of the decision.

The review panel has heard and considered the application of __________________________

(name of board representative or physician)

and has decided

☐ to make an order authorizing the following treatment *(nature of treatment)*:


to be administered to ___________________________________________(name of formal patient) ________________________________.


☐ to refuse to make an order authorizing the following treatment *(nature of treatment)*:


to be administered to ___________________________________________(name of formal patient) ________________________________.

Date of Decision: ____________________________ (date)

This decision may be appealed to the Court of Queen’s Bench within 14 days after receipt of this decision.

__________________________________________ (signature of chair of review panel) ______________________________________ (printed name of chair)
The formal patient (does) (does not) object to the nearest relative,

__________________________________________________________

(name of nearest relative)

receiving notice of the decision.

The review panel has heard and considered the application of

__________________________________________________________

(name of applicant)

and has decided

☐ to order that

__________________________________________________________

(name of patient)

be transferred back to

__________________________________________________________

(name of correctional facility).

☐ to refuse to make an order.

☐ to cancel the admission certificates or renewal certificates, if any.

☐ to refuse to cancel admission certificates or renewal certificates for the following reasons:

Date of Decision: ________________________________ (date)

This decision may be appealed to the Court of Queen’s Bench within 14 days after receipt of this decision.

__________________________________________ (signature of chair of review panel)  ______________ (printed name of chair)
Decision of Review Panel Regarding Admission Certificates, Renewal Certificates or Community Treatment Orders (Form 17)

Mental Health Act Sections 38(1) and (1.1) and 41

Note: Place an “X” in the appropriate box.

______ (name of formal patient or person who is subject to the community treatment order.) (does) (does not) object
to the nearest relative, _________________________________________________________________
(receiving notice of the decision.)

The review panel has heard and considered the application of ___________________________________,
bearing a relationship of ____________________________ to _______________________________________________________, and has decided

☐ to cancel the admission certificates or renewal certificates relating to the person named above.

☐ to refuse to cancel the admission certificates or renewal certificates relating to the person named above for the following reasons: _____________________________________________

☐ to refuse to cancel the community treatment order relating to the person named above for the following reasons: ________________________________________________________

☐ to cancel the community treatment order relating to the person named above.

☐ to refuse to cancel the community treatment order relating to the person named above for the following reasons:

Date of Decision: ____________

This decision may be appealed to the Court of Queen’s Bench within 14 days of receipt of this decision.

__________________________ (signature of chair of review panel) ______________________ (printed name of chair)

MH1993 (2010/01)
The review panel has heard and considered an application deemed by section 39 of the Act to have been made by ______________________________________________________________ and has decided,

(name of formal patient or person who is subject to the community treatment order.)

(does) (does not) object

to the nearest relative, ________________________________________________________________

(name of nearest relative)

receiving notice of the decision.

The review panel has heard and considered an application deemed by section 39 of the Act to have been made by ________________________________________________________________ and has decided,

(name of formal patient or person who is subject to the community treatment order.)

☐ to cancel the renewal certificates relating to the person named above.

Note:
Place an “X” in the appropriate box.

☐ to refuse to cancel the renewal certificates relating to the person named above for the following reasons:

☐ to cancel the community treatment order relating to the person named above.

☐ to refuse to cancel the community treatment order relating to the person named above for the following reasons:

Date of Decision: ____________________________
(date)

This decision may be appealed to the Court of Queen’s Bench within 14 days of receipt of this decision.

(signature of chair of review panel) ____________________________ (printed name of chair) ____________________________
PART I
Issuing Psychiatrist’s Examination

Name of Person: _______________________________

Person’s Address (if known):

________________________________________________________________________

Phone (if known): _______________________________

Date of Birth: _________________________________

Personal Health Care Number _________________

I, ______________________________________ of ______________________________________

(print name of psychiatrist or designated physician) of ________________________________

(business address)

_________________________________________, am:

☐ a psychiatrist

OR

☐ acting as a designated physician pursuant to section 9.7 of the Mental Health Act, and I confirm I have consulted with a psychiatrist prior to the issuance of this community treatment order;

and I am the issuing psychiatrist of this community treatment order.

I certify that I personally examined this person on _________________ at ________________ at

(date) (time)

________________________________________________________________________ with the following results:

1. The person examined

   (a) in my opinion, is suffering from mental disorder,

   (b) has

       ☐ during the immediately preceding 3-year period, on 2 or more occasions, or for a total of at least 30 days,

       ☐ been a formal patient in a facility,

       ☐ been in an approved hospital or been lawfully detained in a custodial institution where there is satisfactory evidence that while there the person would have met the criteria set out in section 2(a) and (b) of the Mental Health Act at the time or those times,

       ☐ both been a formal patient in a facility and been in an approved hospital or lawfully detained in a custodial institution where there is satisfactory evidence that while there the person would have met the criteria set out in section 2(a) and (b) of the Mental Health Act at the time or those times,
Name of Person: _______________________________

PHN: ______________________________________

or

☐ within the immediately preceding 3-year period, been subject to a community treatment order,

or

☐ in my opinion has, while living in the community, exhibited a pattern of recurrent or repetitive behaviour that indicates the person is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community,

(c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

(d) is able to comply with the treatment or care set out in this community treatment order.

2. The facts on which I formed the above opinions are as follows:

3. I am satisfied that the treatment or care set out in Part III of this community treatment order exists in the community, is available to the person and will be provided to the person.

__________________________  ____________________________
(signature of issuing psychiatrist)  (date and time)
PART II
Second Examination by Physician

Name of Person: __________________________________________

Person’s Address (if known):
________________________________________________________

Phone (if known): ________________________________________

Date of Birth: __________________________________________

Personal Health Care Number _____________________________

I, _______________________________________________________
(print name of physician) of __________________________________
(business address)

_______________________________________________________
(phone number)

certify that I personally examined this person on ______________ at __________ at
	(date) (time)

_______________________________________________________
(place of examination)

with the following results:

1. The person examined

   (a) in my opinion, is suffering from mental disorder,

   (b) has

   ☐ during the immediately preceding 3-year period, on 2 or more occasions, or for a total
   of at least 30 days,

   ☐ been a formal patient in a facility,

   ☐ been in an approved hospital or been lawfully detained in a custodial
   institution where there is satisfactory evidence that while there the
   person would have met the criteria set out in section 2(a) and (b) of
   the Mental Health Act at the time or those times,

   ☐ both been a formal patient in a facility and been in an approved
   hospital or lawfully detained in a custodial institution where there is
   satisfactory evidence that while there the person would have met the
   criteria set out in section 2(a) and (b) of the Mental Health Act at the
   time or those times,

   ☐ within the immediately preceding 3-year period, been subject to a
   community treatment order,

   ☐ in my opinion has, while living in the community, exhibited a pattern of
   recurrent or repetitive behaviour that indicates the person is likely to
   cause harm to the person or others or to suffer substantial mental or
   physical deterioration or serious physical impairment if the person does
   not receive continuing treatment or care while living in the
   community,
2. The facts on which I formed the above opinions are as follows:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
___________________________________________________________________________________.

3. I am satisfied that the treatment or care set out in Part III of this community treatment order exists in the community, is available to the person and will be provided to the person.

(c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

(d) is able to comply with the treatment or care set out in this community treatment order.

Name of Person: _______________________________
PHN:________________________________________

_____________  (signature of physician)  ________________  (date and time)
PART III
Treatment and Care Plan

Name of Person: ________________________________________

Person’s Address (if known):

________________________________________________________________________

Phone (if known): ______________________________________

Date of Birth: ________________________________________

Personal Health Care Number _________________________

The person who is subject to this community treatment order must

1. take the following medications (which may be adjusted where indicated by clinical need):

☐

☐ see attached list.

2 (a). attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider’s designate:

Provider Name: ________________________________ Contact Number: ____________________

Profession/Role: ________________________________

Description of Treatment or Care: _______________________________________________________

____________________________________________________________________________________

Location (if applicable) ________________________________

Date/Time or Frequency (if applicable): ____________________________________________________

_____________________________________________ _________________________

(signature of provider OR person authorized by regional health authority) (date)
Name of Person: ______________________________
PHN:______________________________________

2 (b). attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider’s designate:

Provider Name: ______________________________ Contact Number: ______________
Profession/Role: ____________________________
Description of Treatment or Care: ______________________________________________________
_________________________________________________________________________________
Location (if applicable) ________________________________________________________________
Date/Time or Frequency (if applicable): _________________________________________________

_____________________________________________ _________________________
(signature of provider OR person authorized by ____________________________
regional health authority) (date)

2 (c). attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider’s designate:

Provider Name: ______________________________ Contact Number: ______________
Profession/Role: ____________________________
Description of Treatment or Care: ______________________________________________________
_________________________________________________________________________________
Location (if applicable) ________________________________________________________________
Date/Time or Frequency (if applicable): _________________________________________________

_____________________________________________ _________________________
(signature of provider OR person authorized by ____________________________
regional health authority) (date)

2 (d). attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider’s designate:

Provider Name: ______________________________ Contact Number: ______________
Profession/Role: ____________________________
Description of Treatment or Care: ______________________________________________________
_________________________________________________________________________________
Location (if applicable) ________________________________________________________________
Date/Time or Frequency (if applicable): _________________________________________________

_____________________________________________ _________________________
(signature of provider OR person authorized by ____________________________
regional health authority) (date)
Name of Person: __________________________________________
PHN: __________________________________________

2 (e). attend the following appointments with, accept telephone contact or home visits from, or receive
treatment or care from the following provider(s) or the provider’s designate:

Provider Name: __________________________________________  Contact Number: _________________
Profession/Role: __________________________________________
Description of Treatment or Care: ________________________________

Location (if applicable) __________________________________________
Date/Time or Frequency (if applicable): ______________________________

_____________________________________________ _________________________
(signature of provider OR person authorized by regional health authority)  (date)

(Where treatment or care is provided by a regional health authority provider, a person authorized by the regional health authority must sign the Plan before it is issued. Where treatment or care is provided by a provider other than a regional health authority provider, that provider must sign the Plan before it is issued.)

Reporting obligations
In accordance with the Community Treatment Order Regulation, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and
(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.
PART IV
Person Responsible for Supervision of Community Treatment Order

Name of Person: _______________________________

Person’s Address (if known):

____________________________________________

Phone (if known): ______________________________

Date of Birth: ________________________________

Personal Health Care Number __________________

The person responsible for the supervision of this community treatment order is

☐ the issuing psychiatrist, or

☐ ________________________________

(name of physician who is responsible for the supervision of the community treatment order)

____________________________________________

(print name of physician) ______________________________________

(business address)

____________________________________________

(phone number), am responsible for the supervision of this community
treatment order.

____________________________________________  ________________

(signature of issuing psychiatrist or supervising physician) (date)

Note: This form is used to indicate whether the person subject to the community
treatment order will, after issuance of the community treatment order, continue
to be under the treatment and care of the issuing psychiatrist OR whether a new
physician has accepted responsibility for supervising the order. If the person is
transferred to another physician, the accepting physician MUST SIGN the
acceptance before it is effective.
PART V
Consent

Name of Person: ______________________________

Person’s Address (if known):
____________________________________________

Phone (if known): ______________________________

Date of Birth: _________________________________

Personal Health Care Number ____________________

Consent by person who is subject to a community treatment order

I, ________________________________, am the person subject to this community treatment order and I consent to the issuing of this community treatment order.

__________________________________________  (signature)  ____________________________  (date)

Consent by substitute decision-maker

I, ________________________________, am the person authorized under section 28(1) of the Mental Health Act to make treatment decisions on behalf of the person who is subject to this community treatment order and I hereby consent to the issuing of this community treatment order.

__________________________________________  (signature of substitute decision-maker)  ____________________________  (date)

No consent

I, the issuing psychiatrist, have not obtained consent to the issuing of this community treatment order. I am of the opinion that the person who is subject to this community treatment order has, while living in the community, exhibited a history of not obtaining or continuing with treatment or care that is necessary to prevent the likelihood of harm to others, and the issuance of a community treatment order is reasonable in the circumstances and would be less restrictive than retaining the person as a formal patient.

__________________________________________  (signature of issuing psychiatrist)  ____________________________  (date)
PART I
Issuing Psychiatrist’s Examination

Name of Person: _______________________________

Person’s Address (if known):
____________________________________________

Phone (if known): ______________________________

Date of Birth: _________________________________

Personal Health Care Number ____________________

I, ________________________________________ of ________________________________________

(print name of psychiatrist or designated physician) (business address)

(phone number), am:

☐ a psychiatrist

OR

☐ acting as a designated physician pursuant to section 9.7 of the Mental Health Act, and I confirm I have consulted with a psychiatrist prior to the renewal of this community treatment order;

and I am the issuing psychiatrist in relation to the renewal of this community treatment order.

I certify that I personally examined this person on _____________________ at ______________ at __________________________________________________________________________ with the following results:

(date) (time) (place of examination)

1. The person examined

   (a) in my opinion, continues to suffer from mental disorder,

   (b) is currently subject to a community treatment order,

   (c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

   (d) is able to comply with the treatment or care set out in this community treatment order.
2. The facts on which I formed the above opinions are as follows: ______________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

3. I am satisfied that the treatment or care set out in Part III of this renewal exists in the community, is available to the person and will be provided to the person.

________________________________________   _______________________________
(signature of issuing psychiatrist)              (date and time)
PART II
Second Examination by Physician

Name of Person: _______________________________

Person’s Address (if known): ________________________________________________

Phone (if known): ________________________________

Date of Birth: ________________________________

Personal Health Care Number ____________________

I, ________________________________________ of ________________________________________

____________________________
(print name of physician) (business address)

____________________________
(phone number)

certify that I personally examined this person on _____________________ at ______________ at
____________________________
(date) (time) (place of examination)

1. The person examined

(a) in my opinion, continues to suffer from mental disorder,

(b) is currently subject to a community treatment order,

(c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

(d) is able to comply with the treatment or care set out in this community treatment order.

2. The facts on which I formed the above opinions are as follows:

3. I am satisfied that the treatment or care set out in Part III of this renewal exists in the community, is available to the person and will be provided to the person.

________________________________________
(signature of physician) _____________________
(date and time)
PART III
Treatment and Care Plan

Name of Person: ______________________________
Person’s Address (if known):
__________________________________________
Phone (if known): ____________________________
Date of Birth: ______________________________
Personal Health Care Number __________________

The person who is subject to this community treatment order must

1. take the following medications (which may be adjusted where indicated by clinical need):

☐ 

or

☐ see attached list.

2 (a). attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider’s designate:

Provider Name: _______________________________ Contact Number: _________________________
Profession/Role: ____________________________
Description of Treatment or Care: ___________________________________________________________  
____________________________________________________________________________________
Location (if applicable) _________________________________________________________________
Date/Time or Frequency (if applicable): ______________________________________________________

_____________________________________________  ____________________________
(signature of provider OR person authorized by regional health authority)  (date)
Name of Person: ________________________________

PHN:_______________________________________

2 (b). attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider’s designate:

Provider Name: ___________________________________________ Contact Number: __________________
Profession/Role: _____________________________________________________________
Description of Treatment or Care: ___________________________________________________________
____________________________________________________________________________________
Location (if applicable) ________________________________________________________________
Date/Time or Frequency (if applicable): ________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
_________________________________________ _________________________________________
/signature of provider OR person authorized by regional health authority) (date)

2 (c). attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider’s designate:

Provider Name: ___________________________________________ Contact Number: __________________
Profession/Role: _____________________________________________________________
Description of Treatment or Care: ___________________________________________________________
____________________________________________________________________________________
Location (if applicable) ________________________________________________________________
Date/Time or Frequency (if applicable): ________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
_________________________________________ _________________________________________
/signature of provider OR person authorized by regional health authority) (date)

2 (d). attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider’s designate:

Provider Name: ___________________________________________ Contact Number: __________________
Profession/Role: _____________________________________________________________
Description of Treatment or Care: ___________________________________________________________
____________________________________________________________________________________
Location (if applicable) ________________________________________________________________
Date/Time or Frequency (if applicable): ________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
_________________________________________ _________________________________________
/signature of provider OR person authorized by regional health authority) (date)
Renewal of Community Treatment Order (Form 20)

Mental Health Act Section 9.3

Name of Person: ______________________________________

PHN: ________________________________________________

Section 9.3

2 (e). attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider’s designate:

Provider Name: ______________________________________ Contact Number: __________________

Profession/Role: ______________________________________

Description of Treatment or Care: _______________________________________________________
___________________________________________________________________________________

Location (if applicable) _________________________________________________________________

Date/Time or Frequency (if applicable): __________________________________________________

_____________________________________________ _________________________

(signature of provider OR person authorized by regional health authority) (date)

(Where treatment or care is provided by a regional health authority provider, a person authorized by the regional health authority must sign the Plan before it is issued. Where treatment or care is provided by a provider other than a regional health authority provider, that provider must sign the Plan before it is issued.)

Reporting obligations

In accordance with the Community Treatment Order Regulation, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and

(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.
PART IV
Person Responsible for Supervision of Community Treatment Order

Name of Person: _______________________________

Person’s Address (if known):
____________________________________________

Phone (if known): ______________________________

Date of Birth: _________________________________

Personal Health Care Number ____________________

The person responsible for the supervision of this community treatment order is

☐ the issuing psychiatrist, or

☐ _________________________________________

(name of physician who is responsible for the supervision of the community treatment order)

I, ________________________________________ of ________________________________________, am responsible for the supervision of this community treatment order.

__________________________________________
(print name of physician) ______________________
(business address)

__________________________ (phone number)

, am responsible for the supervision of this community treatment order.

_______________________________________________________________________________
(name of physician who is responsible for the supervision of the community treatment order)

__________________________________________
(signature of issuing psychiatrist or supervising physician) ______________________
(date)

Note: This form is used to indicate whether the person subject to the community treatment order will, after renewal of the community treatment order, continue to be under the treatment and care of the issuing psychiatrist OR whether a new physician has accepted responsibility for supervising the order. If the person is transferred to another physician, the accepting physician MUST SIGN the acceptance before it is effective.
Renewal of Community Treatment Order (Form 20)

Mental Health Act Section 9.3

PART V
Consent

Name of Person: ________________________________

Person’s Address (if known):

_____________________________________________

Phone (if known): ______________________________

Date of Birth: _________________________________

Personal Health Care Number ____________________

Choose one of the three options.

☐ Consent by person who is subject to a community treatment order

I, ____________________________________________, am the person subject to this community treatment order and I consent to the renewal of this community treatment order.

__________________________________________  ____________________
(signature)                                (date)

☐ Consent by substitute decision-maker

I ________________________________ am the person authorized under section 28(1) of the Mental Health Act to make treatment decisions on behalf of the person who is subject to this community treatment order and I hereby consent to the renewal of this community treatment order.

__________________________________________  ____________________
(signature of substitute decision-maker)        (date)

☐ No consent

I, the issuing psychiatrist, have not obtained consent to the renewal of this community treatment order. I am of the opinion that the person who is subject to this community treatment order has, while living in the community, exhibited a history of not obtaining or continuing with treatment or care that is necessary to prevent the likelihood of harm to others, and the renewal of a community treatment order is reasonable in the circumstances and would be less restrictive than retaining the person as a formal patient.

__________________________________________  ____________________
(signature of issuing psychiatrist)        (date)
Amendments to Community Treatment Order (Form 21)

Mental Health Act Section 9.4

Name of Person: ________________________________

Person’s Address (if known):

_____________________________________________

Phone (if known): ______________________________

Date of Birth: _________________________________

Personal Health Care Number ________________

I, ___________________________________________ of ______________________________________, __________________________, am:

☐ a psychiatrist

OR

☐ acting as a designated physician pursuant to section 9.7 of the Mental Health Act, and I confirm I have consulted with a psychiatrist prior to the amendment of this community treatment order,

and I am the issuing psychiatrist of this amended community treatment order.

I amend the community treatment order for this person by:

☐ amending the name of the person responsible for the supervision of the community treatment order as follows:

Effective on the date below I, ___________________________________________ of ______________________________________ (business address) __________________________, am responsible for the supervision of this community treatment order.

_________________________________________ _________________________

(signature of supervising physician) (effective date)

☐ amending the treatment and care plan as follows:

The person who is subject to this community treatment order must

1. take the following medications (which may be adjusted according to clinical need):

☐ __________________________________________

OR

☐ see attached list.
2 (a). attend the following appointments with, accept telephone contact or home visits from, or receive
treatment or care from the following provider(s) or the provider’s designate:

Provider Name: ______________________________ Contact Number: ________________

Profession/Role: ____________________________

Description of Treatment or Care:

____________________________________________________________________________________

Location (if applicable) ______________________________

Date/Time or Frequency (if applicable): ________________________________

____________________________________________________________________________________

(signature of provider OR person authorized by regional health authority) ______________________ (date)

2 (b). attend the following appointments with, accept telephone contact or home visits from, or receive
treatment or care from the following provider(s) or the provider’s designate:

Provider Name: ______________________________ Contact Number: ________________

Profession/Role: ____________________________

Description of Treatment or Care:

____________________________________________________________________________________

Location (if applicable) ______________________________

Date/Time or Frequency (if applicable): ________________________________

____________________________________________________________________________________

(signature of provider OR person authorized by regional health authority) ______________________ (date)

2 (c). attend the following appointments with, accept telephone contact or home visits from, or receive
treatment or care from the following provider(s) or the provider’s designate:

Provider Name: ______________________________ Contact Number: ________________

Profession/Role: ____________________________

Description of Treatment or Care:

____________________________________________________________________________________

Location (if applicable) ______________________________

Date/Time or Frequency (if applicable): ________________________________

____________________________________________________________________________________

(signature of provider OR person authorized by regional health authority) ______________________ (date)
2 (d). attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider’s designee:

Provider Name: ____________________________  Contact Number: __________________

Profession/Role: ____________________________

Description of Treatment or Care:
____________________________________________________________________________________

Location (if applicable) ________________________________________________________________

Date/Time or Frequency (if applicable): __________________________________________________

_____________________________________________ _________________________

(signature of provider OR person authorized by regional health authority)        (date)

2 (e). attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider’s designee:

Provider Name: ____________________________  Contact Number: __________________

Profession/Role: ____________________________

Description of Treatment or Care:
____________________________________________________________________________________

Location (if applicable) ________________________________________________________________

Date/Time or Frequency (if applicable): __________________________________________________

_____________________________________________ _________________________

(signature of provider OR person authorized by regional health authority)        (date)

(Where treatment or care is provided by a regional health authority provider, a person authorized by the regional health authority must sign the Plan before it is issued. Where treatment or care is provided by a provider other than a regional health authority provider, that provider must sign the Plan before it is issued.)
Amendments to
Community Treatment Order (Form 21)

Mental Health Act Section 9.4

3. The person who is subject to the community treatment order is no longer required to:

I have explained the above amendment(s) to

☐ the person who is subject to this community treatment order,

OR

☐ the substitute decision-maker for the person who is subject to this community treatment order.

_____________________________________________ _________________________
(signature of psychiatrist or designated physician) (date)

Reporting obligations
In accordance with the Community Treatment Order Regulation, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and

(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.
Name of Person: ____________________________________
Person’s Address (if known):
__________________________________________________
Phone (if known): __________________________________
Date of Birth: _____________________________________
Personal Health Care Number _________________________

Note: Section 14(5) requires that this notice be sent to the person subject to the CTO, to persons as required by section 14(1.1)(b) and to the person’s family doctor, if known.

☐ Cancellation of community treatment order

I, ___________________________ of _________________________
(name of psychiatrist or designated physician) (business address)

( ) a psychiatrist,

or

( ) acting as a designated physician pursuant to section 9.7 of the Mental Health Act, and I confirm I have consulted with a psychiatrist prior to the cancellation of this community treatment order,

and

I cancel this person’s community treatment order because this person no longer meets the criteria specified in section 9.1(1)(b) to (d) of the Mental Health Act.

☐ Expiry of community treatment order

This person’s community treatment order has expired.

Continued Treatment Recommendation (if applicable)

I recommend continued treatment and care as follows:

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

___________________________________________________________________________________

( ) a psychiatrist,

or

( ) acting as a designated physician pursuant to section 9.7 of the Mental Health Act, and I confirm I have consulted with a psychiatrist prior to the cancellation of this community treatment order,

and

I cancel this person’s community treatment order because this person no longer meets the criteria specified in section 9.1(1)(b) to (d) of the Mental Health Act.

Notice:
You are no longer subject to a community treatment order effective on the date and time written above. However, this form may contain information about treatment and care that your health provider is recommending you continue to receive.
Name of Person: ________________________________

Person’s Address (if known):
______________________________________________

Phone (if known): ________________________________

Date of Birth: ________________________________

To all or any peace officers in Alberta:

I, ___________________________________________ of ________________________________________
(print name of psychiatrist or designated physician) (business address)
__________________________________________, am:
(phone number)

☐ a psychiatrist

OR

☐ acting as a designated physician pursuant to section 9.7 of the Mental Health Act, and I confirm I have consulted with a psychiatrist prior to the issuance of this apprehension order,

and I have reasonable grounds to believe that ___________________________________________ has
(name of person who is subject to community treatment order)
failed to comply with his/her community treatment order. The reasons for my belief are as follows:

I am satisfied that efforts that are reasonable in the circumstances have been made to

(a) inform the person who is named in this order that the person has failed to comply with the person’s community treatment order,

(b) inform the person of the possibility that I may issue an order for apprehension and assessment of the person if the person continues to fail to comply with the community treatment order, and of the possible consequences of that assessment, and

(c) provide reasonable assistance to the person to comply with the community treatment order,

and that the person continues to fail to comply with his/her community treatment order.
Patient Name: ____________________

This authorizes you to

(a) apprehend the person who is named in this order and to convey the person to

_____________________________ for an examination,

(name of facility)

(b) take reasonable measures, including the entering of premises and the use of physical

restraint, to apprehend the person who is named in this order and to take the person into

custody for the purpose of conveying the person to the facility, and

(c) while the person is being conveyed to the facility, to care for, observe, detain and control the

person.

_____________________________ _________________________

(signature of psychiatrist or designated physician) (date and time)

This apprehension order expires 30 days after the date of issue.

Note: A person conveyed to a facility under this order, must, as soon as practicable but in any case within 72 hours after arrival at the facility, be examined by 2 physicians, one of whom must be a psychiatrist.
Community Treatment Order
Examination on Apprehension (Form 24)

Mental Health Act Section 9.6

I, _________________________________________ of _______________________________________, am:

(print name of psychiatrist, physician or designated physician)
(phone number)

acting as a designated physician pursuant to section 9.7 of the Mental Health Act, and I confirm I have consulted with a psychiatrist prior to the issuance of this community treatment order;

OR

☐ a psychiatrist

OR

☐ acting as a designated physician pursuant to section 9.7 of the Mental Health Act, and I confirm I have consulted with a psychiatrist prior to the issuance of this community treatment order;

OR

☐ a physician,

and I certify that I personally examined this person on __________________ at ______________ at __________________
(date) (time)
(place of examination)

☐ the person’s community treatment order should be cancelled and the person should be released without being subject to a community treatment order (also complete Form 22),

OR

☐ the person’s community treatment order should be continued and amendments to it are not necessary,

OR

☐ the person’s community treatment order should be continued but amendments to it are necessary (also complete Form 21)

OR

☐ the person’s community treatment order should be cancelled and admission certificates issued in accordance with sections 2 and 6 of the Mental Health Act (also complete Form 1).

(print name of psychiatrist, physician or designated physician) ______________________ (date and time)
Designation of Physician (Form 25)

Mental Health Act Section 9.7

I, ________________________________________, of ___________________________, pursuant to section 9.7 of the Mental Health Act, designate the following physician to act in the place of a psychiatrist for the purpose of issuing, renewing, amending or cancelling a community treatment order or issuing an apprehension order when no psychiatrist is available to carry out those functions:

__________________________________________
(name of designated physician)

__________________________________________
(signature of person authorized by board or regional health authority)  ______________________
(date)

I acknowledge this designation and the requirement to consult with a psychiatrist prior to exercising this authority.

__________________________________________
(signature of designated physician)
TO:
Name of Person: _______________________

Person’s Address (if known):

____________________________________

Phone (if known): _______________________

Date of Birth: _________________________

Personal Health Care Number ___________

☐ You are now subject to a community treatment order (attach Form 19) pursuant to section 9.1 of the Mental Health Act. The reason for issuance of the community treatment order is:

☐ The attached community treatment order has been renewed (attach Form 20) pursuant to section 9.3 of the Mental Health Act. The reason for the renewal of the community treatment order is:

☐ Your community treatment order has been amended (attach Form 21) pursuant to section 9.4 of the Mental Health Act. The reason for the amendment of the community treatment order is:

______ _______________________
(signature of issuing psychiatrist) (phone number) (date)

Important Information:
You have a right to apply to a review panel for cancellation of this community treatment order.

You may apply for cancellation of this community treatment order by filing an application with the chair of your review panel. An application may be filed by you, your agent, your guardian or another person on your behalf.

____________________________________   _______________________
(name of chair of appropriate review panel) (address of appropriate review panel)
Community Treatment Order
Non-compliance Report (Form 27)

Mental Health Act Section 9.1(2)(f)

Name of Person: _______________________________________________________

Person’s Address (if known):

_______________________________________________________________________

Phone (if known): ______________________________________________________

Date of Birth: _________________________________________________________

Personal Health Care Number _________________

The person who is subject to this community treatment order has failed to comply with the following requirements of the treatment or care plan on the dates specified:

Date: ___________________ Treatment or Care: ____________________________________________

(month/day/year)

Date: ___________________ Treatment or Care: ____________________________________________

(month/day/year)

Date: ___________________ Treatment or Care: ____________________________________________

(month/day/year)

Date: ___________________ Treatment or Care: ____________________________________________

(month/day/year)

___________________________________________________________________

(signature of treatment or care provider) (date)

___________________________________________________________________

(print name of treatment or care provider)

___________________________________________________________________

(phone number)

Reporting obligations
In accordance with the Community Treatment Order Regulation, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and

(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.
Appendix V: Investigations of Designated Facilities
Investigations of Designated Facilities

Note: the wording in this section has been taken from their respective websites.

**The Office of the Ombudsman**

Investigates complaints dealing with administrative fairness, is impartial and independent from government, and responds to the resolution of patient concerns by publicly funded health care facilities, programs and services.

The Ombudsman does not act as an advocate for the complainant or represent government departments.

The Ombudsman’s website is www.ombudsman.ab.ca/

**The Protection for Persons in Care Act Office**

Investigates reports of abuse or safety concerns for adults in publicly funded facilities including hospitals, senior lodges and nursing homes.

Every individual or service provider who has reasonable and probable grounds to believe that there has been or is abuse against a client must report the incident or incidents.

The Office’s website is www.seniors.gov.ab.ca/CSS/persons_in_care/

**The Health Facilities Review Committee**

Monitors the quality of care, treatment and standards of accommodation provided to patients and residents in health care facilities.

The committee also investigates complaints that cannot be resolved at the facility-level.

The committee’s website is www.health.alberta.ca/about/HFRC.html
Appendix VI: CTO Forms Completion and Distribution - Chart
**Process for Completing and Distributing Community Treatment Order Forms**

**NOTE:** This information is limited to the required distribution of CTO forms as specified in the *Mental Health Act of Alberta*. It does not reflect all requirements for notification. Further processes to be developed within Zones, Facilities and Communities.

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<table>
<thead>
<tr>
<th>Form Name</th>
<th>Completed by</th>
<th>Distributed by</th>
<th>Distributed to</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form 07 Information</td>
<td>Informant</td>
<td>Informant</td>
<td>1. Provincial Court (for a Judge)</td>
<td></td>
</tr>
<tr>
<td>Form 08 Warrant</td>
<td>Judge</td>
<td>Court</td>
<td>1. Peace Officer</td>
<td>Expires 7 days.</td>
</tr>
<tr>
<td>Form 09 Extension of Warrant</td>
<td></td>
<td></td>
<td></td>
<td>Extends warrant a further 7 days (once)</td>
</tr>
<tr>
<td>Form 10 Statement of Peace Officer on Apprehension</td>
<td>Peace Officer</td>
<td>Peace Officer</td>
<td>ORIGINAL to:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>1. Facility</td>
<td></td>
</tr>
<tr>
<td>Form 12 Application for Review Panel Hearing</td>
<td>Applicant (person subject to CTO, agent, guardian, anyone on their behalf, Board or Delegate)</td>
<td>Applicant</td>
<td>1. Review Panel Chair</td>
<td></td>
</tr>
<tr>
<td>Form 13 Notice of Hearing Before Review Panel</td>
<td>Chair of Review Panel</td>
<td>Chair of Review Panel</td>
<td>1. Person subject to CTO</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Person’s agent, guardian or any other person referred to in MHA 28(1) if any ie: Substitute Decision Maker</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>3. One person designated by Person subject to CTO (if applicable)</td>
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<td>4. Nearest relative unless Person objects</td>
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<td>5. Any other person the Chair feels may be affected by the application</td>
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<td></td>
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<td>6. Regional Health Authority [AHS Designate*]</td>
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<td>7. Last Psychiatrist or “Designated Physician” to issue, amend or renew CTO</td>
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<td>8. Supervisor of CTO</td>
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<td>9. Applicant</td>
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<td></td>
<td>On receipt of application will give at least 7 days notice of hearing</td>
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</tr>
<tr>
<td>Form 17 Decision of Review Panel Regarding Admission Certificates, Renewal Certificates or Community Treatment Orders</td>
<td>Chair of Review Panel</td>
<td>Chair of Review Panel</td>
<td>Every person who received notification of Form 13.</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Make a decision within 24 hours of hearing. Inform people of decision within 24 hours of making the decision.</td>
<td></td>
</tr>
<tr>
<td>Form 18 Decision of Review Panel Regarding Renewal Certificates &amp; Community Treatment Orders (Deemed Application)</td>
<td>Chair of Review Panel</td>
<td>Chair of Review Panel</td>
<td>Every person who received notification of Form 13.</td>
<td></td>
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<td></td>
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<td>Make a decision within 24 hours of hearing. Inform people of decision within 24 hours of making the decision.</td>
<td></td>
</tr>
</tbody>
</table>

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*Original stays with issuer unless otherwise stated. Must be produced if requested for hearing by Review Panel or Court of Queens Bench.*
## Process for Completing and Distributing Community Treatment Order Forms

**NOTE:** This information is limited to the required distribution of CTO forms as specified in the *Mental Health Act of Alberta.* It does not reflect all requirements for notification. Further processes to be developed within Zones, Facilities and Communities.

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<table>
<thead>
<tr>
<th>Form Name</th>
<th>Completed by</th>
<th>Distributed by</th>
<th>Distributed to</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form 19</strong> Issuance Community Treatment Order</td>
<td><strong>Part 1:</strong> Psychiatrist or &quot;Designated Physician&quot; <strong>Part 2:</strong> Physician <strong>Part 3:</strong> Treatment or Care Provider (If care by RHA, then RHA designate) <strong>Part 4:</strong> Psychiatrist or physician responsible for supervising CTO <strong>Part 5:</strong> Person consenting to CTO or Issuing Psychiatrist</td>
<td>a) Issuing Psychiatrist / &quot;Designated Physician&quot; <strong>b) Regional Health Authority [AHS]</strong></td>
<td>1. Person subject to CTO 2. Substitute Decision Maker under MHA 28(1) 3. Regional Health Authority [AHS Designate*] 4. Any person providing treatment or care</td>
<td>On issuance*</td>
</tr>
<tr>
<td><strong>Form 20</strong> Renewal of Community Treatment Order</td>
<td><strong>Part 1:</strong> Psychiatrist or &quot;Designated Physician&quot; <strong>Part 2:</strong> Physician <strong>Part 3:</strong> Treatment or Care Provider (If care by RHA, then RHA designate) <strong>Part 4:</strong> Psychiatrist or physician responsible for supervising CTO <strong>Part 5:</strong> Person consenting to CTO or Issuing Psychiatrist</td>
<td>a) Issuing Psychiatrist / &quot;Designated Physician&quot; <strong>b) Regional Health Authority [AHS]</strong></td>
<td>1. Person subject to CTO 2. Substitute Decision Maker under MHA 28(1) 3. Regional Health Authority [AHS Designate*] 4. Any person providing treatment or care 5. Review Panel: 1st renewal and every 2nd after that</td>
<td>On receipt, promptly</td>
</tr>
<tr>
<td><strong>Form 21</strong> Amendments to Community Treatment Order</td>
<td>A Psychiatrist or &quot;Designated Physician&quot; and depending on the amendment: Supervising Physician OR Treatment or Care Provider (AHS if care provided by AHS)</td>
<td>a) Issuing Psychiatrist / &quot;Designated Physician&quot; <em><em>b) Regional Health Authority [AHS Designate</em>]</em>*</td>
<td>1. Person subject to CTO 2. Substitute Decision Maker under MHA 28(1) 3. Regional Health Authority [AHS Designate*] 4. Any person providing treatment or care</td>
<td></td>
</tr>
</tbody>
</table>

* Not specified in the MHA, recommended for flow of CTO process.

Remember to document actions taken with any forms on patient chart/file. (i.e.: date distributed, method of distribution, by who and to whom)
**Process for Completing and Distributing Community Treatment Order Forms**

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<tbody>
<tr>
<td>Form 22 Community Treatment Order Cancellation or Expiry</td>
<td>CANCELLATION A Psychiatrist or “Designated Physician” OR EXPIRY Supervising Physician</td>
<td>CANCELLATION A Psychiatrist or “Designated Physician” OR EXPIRY Supervising Physician</td>
<td>Along with any recommendations for treatment (MHA 14(5)) 1. Person subject to CTO 2. Substitute Decision Maker under MHA 28(1) 3. Regional Health Authority [AHS Designate*] 4. Any person providing treatment or care 5. Family Doctor (if known)</td>
<td>On issuance*</td>
</tr>
<tr>
<td>Form 23 Community Treatment Order Apprehension Order</td>
<td>A Psychiatrist or “Designated Physician”</td>
<td>a) A Psychiatrist or “Designated Physician”</td>
<td>ORIGINAL to: (may fax and send original by mail) 1. Peace Officer Copy to: 2. Regional Health Authority [AHS Designate*]</td>
<td>Expires 30 days</td>
</tr>
<tr>
<td>Form 24 Community Treatment Order Examination on Apprehension</td>
<td>Two Physicians (one of who must be a Psychiatrist or “Designated Physician”)</td>
<td>a) Two Physicians</td>
<td>1. Issuing Psychiatrist / “Designated Physician”*</td>
<td>Examination as soon as practicable, within 72 hours of arrival at facility</td>
</tr>
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<td></td>
<td>b) Issuing Psychiatrist / “Designated Physician”</td>
<td>2. Regional Health Authority [AHS Designate*]</td>
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<td></td>
<td>c) Regional Health Authority [AHS Designate*]</td>
<td>1. Other Regional Health Authorities providing services to the person on the CTO [AHS is the sole RHA but it is recommended to distribute to the AHS contacts in applicable zones, facilities, and communities*, include CTO Coordinator for the Zone*] 2. Person supervising CTO (if they are not the Issuing Psychiatrist) 3. Person responsible for providing written statement on Form 26 (issuing psychiatrist) 4. One person designated by Person subject to CTO (if applicable)</td>
<td></td>
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</tr>
</tbody>
</table>

*Not specified in the MHA, recommended for flow of CTO process.*

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8/27/2010
**Process for Completing and Distributing Community Treatment Order Forms**

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<tr>
<td><strong>Form 25</strong> Community Treatment Order Designation of Physician</td>
<td>Person authorized by Board or AHS; acknowledged by “Designated Physician”</td>
<td>a) Regional Health Authority [AHS]</td>
<td>1. Retain Form 25 in records*</td>
<td>Designation maximum term is 2 years. May be renewed.</td>
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<td>2. Notification to treatment providers*</td>
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<tr>
<td><strong>Form 26</strong> Community Treatment Order Written Statement</td>
<td>Issuing Psychiatrist/ “Designated Physician”</td>
<td>Issuing Psychiatrist / “Designated Physician”</td>
<td>ORIGINAL to:</td>
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<td>1. Person subject to CTO</td>
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<td>Copies to:</td>
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<td>2. Substitute Decision Maker under MHA s. 28</td>
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<td>3. Any person providing treatment or care</td>
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<td>4. Regional Health Authority [AHS Designate]</td>
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<td>5. Maintain copy on file*</td>
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<td>b) Regional Health Authority [AHS Designate]*)</td>
<td>1. Person supervising CTO (if they are not the Issuing Psychiatrist)</td>
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<td></td>
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<td>2. Other Regional Health Authorities providing services to the person on the CTO [AHS is the sole RHA but it is recommended to distribute to the AHS contacts in applicable zones, facilities, and communities*, include CTO Coordinator for the Zone*]</td>
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<td>3. One person designated by Person subject to CTO (if applicable)</td>
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<tr>
<td><strong>Form 27</strong> Community Treatment Order Non-compliance Report</td>
<td>Treatment or Care Provider</td>
<td>a) Treatment or Care Provider</td>
<td>1. Regional Health Authority [AHS Designate*]</td>
<td>To be completed within 24 hours of becoming aware of failure to comply</td>
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<td>2. Regional Health Authority [AHS Designate*]</td>
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<td></td>
<td>1. CTO Supervising Physician</td>
<td>Copies to be provided within 24 hours from receipt of form</td>
</tr>
</tbody>
</table>

“*Issuing Psychiatrist” means the psychiatrist, or the physician designated in accordance with section 9.7 of the Act, who last issued, renewed, or amended a CTO. (CTO Reg 1)

“Designated Physician”: If psychiatrist not available a physician may be designated under MHA 9.7(1). Designated Physician must consult with a psychiatrist prior to issuing, renewing, amending or canceling a CTO. Designation is for 2 years and may be renewed. Use Form 25 (CTO Reg 5)

**DISCLAIMER:** This document is intended as a guide and should not be used as a legal reference or advice. Please consult a lawyer if in need of clarification or legal advice. The information herein is not fully comprehensive; for complete details please refer to Alberta’s *Mental Health Act* and the accompanying regulations. AHS is not liable in any way for actions based on the use of information contained herein.

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