Addiction and Mental Health

Guide to Alberta's *Mental Health Act*

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Alberta Health Services

Guide to Alberta's *Mental Health Act*

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Obtaining Copies

The guide will be available online at the Alberta Health Services (AHS) website: https://www.albertahealthservices.ca/info/Page3531.aspx

Guide Updates

Please refer to the website above for any changes and/or revisions of a significant nature to the *Guide to Alberta's Mental Health Act*.

This is a revised edition of the guide. Its purpose is to explain the requirements of the *Mental Health Act* in plain, easy-to-understand language. The guide will be updated as provisions of the *Mental Health Act* are brought into force or as the *Mental Health Act* is amended.

Guide to Alberta's Mental Health Act – 2022 Ed.

Additional Sources of Information
Mental Health Act and regulations

The Act and regulations can be viewed online or purchased from:

King's Printer
Main Floor, Park Plaza
10611 – 98 Avenue
Edmonton, AB T5K 2P7
Phone: (780) 427-4952
Website: https://www.alberta.ca/alberta-kings-printer.aspx

Mental Health Act forms

Electronic versions of all the *Mental Health Act* forms are available on the Alberta Health Services website at: https://www.albertahealthservices.ca/info/page1256.aspx
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.

Contents

Information about the Guide

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 (Act), and the associated regulations. Other relevant legislation (e.g., the *Adult Guardianship and Trusteeship 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 legal counsel. Examples herein are for illustrative purposes and should not be viewed as authoritative statements of the law. Readers should consult legal counsel if in need of legal advice or clarification regarding the application of the Act. Further, this guide is not intended to replace or supersede internal policies.

Alberta Health Services (AHS) is not liable in any way for actions based on the use of information contained in this guide.

Questions and answers

A series of questions and answers, found at the end of chapters two through nine, addresses practice issues relevant to both community and hospital settings.

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 December 2021.

Contact Information

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

Provincial Clinical Excellence
Addiction and Mental Health
Alberta Health Services
10101 Southport Road SW
Calgary, AB T2W 3N2

The Alberta Mental Health Act - Introduction

It is estimated that 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 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.

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. In addition, 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.

History of Mental Health Legislation in Alberta

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 1924. Asylums were now called hospitals, and it was recognized that hospitalized individuals were sick and

[1] Slomp, M., Bland, R., Patterson, S., Whittaker, L. (2009). Three-Year Physician Treated Prevalence Rate of Mental Disorders in Alberta. Canadian Journal Psychiatry, 54(3):199–202.

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 more 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.

Further amendments to the *Mental Health Act* were proclaimed in two stages on September 30, 2009 and January 1, 2010, following a lengthy process of consultation and review.[2] Those amendments broadened the criteria for certification to permit earlier intervention and treatment, and introduced community treatment orders (CTOs) to encourage individuals to maintain mental health treatment in the community, ideally reducing the need for hospitalization. The role of Alberta's Mental Health Patient Advocate (Patient Advocate) was expanded to allow the Patient Advocate to respond to and investigate complaints when a person was detained under one admission certificate and to assist persons subject to CTOs. Previously, the Patient Advocate could intervene only if a person had formal patient status, that is, had two admission or two renewal certificates requiring them to be detained in a designated facility.

Recent amendments to the Act were proclaimed in force in stages: September 30, 2020, and March 31, 2021. The amendments made changes to the longstanding definition of "mental disorder" and introduced two new terms: qualified health professional, and secure location. Treatment is now defined and the concept of treatment plans is introduced. Additional changes are highlighted below and explained in further detail throughout the guide.

Definition of Mental Disorder

Mental disorder is defined as 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, but does not include a disorder in which the resulting impairment is persistent and is caused solely by an acquired or

[2] The history and purpose of these amendments is explained in: M. Marshall, *Everything You Want to Know about Changes to the Mental Health Act in Alberta*, Health Law Review (2010), Vol. 19, No. 1.

congenital irreversible brain injury. The change to the definition is supported by the following definitions in section 2.1 of the Mental Health Regulation:

(a) *"irreversible brain injury" means a permanent disruption to the baseline function of the brain or to the structure of the brain caused or likely caused by an identifiable or probable*

(i) *acute external action, including trauma, or*

(ii) *pathophysiological event within the body, including an acute hypoxic event,*

but does not include a permanent disruption caused or likely caused by a neurodegenerative disorder;

(b) *"persistent" means stable and unlikely to improve as a result of treatment.*

Qualified Health Professional

Qualified health professional means a physician or nurse practitioner or a person who is registered under section 33(1)(a) of the *Health Professions Act* as a member of a health profession or of a category within a health profession designated by the *Mental Health Act* regulations for the purposes of all or part of the Mental Health Act. The Minister may designate in the future other qualified health professionals under the *Mental Health Act* regulations, but at this time, a qualified health professional is a psychiatrist, physician, or nurse practitioner. The role of a qualified health professional is set out in Appendix V.

Secure Location

Secure locations are introduced in section 13.1 of the Act and are designated by ministerial order. Peace officers may convey an individual under a Form 8 - Warrant (section 10 of the Act) or under a Form 10 - Statement of Peace Officer on Apprehension (section 12 of the Act) to a secure location (or a designated facility) for assessment and examination. Only the initial assessment and examination takes place at a secure location; this assessment is to occur as soon as possible by a qualified health professional (physician or nurse practitioner). **This guide will be updated when secure locations have been designated by the Minister and are an option for assessment and examination.**

Cancellation Certificate

Form 2.1 – Cancellation of Admission Certificate or Renewal Certificate is introduced in section 31(4) and section 3.1 of the Mental Health Act Forms and Designation Regulation. The physician who cancels admission or renewal certificates of a formal

patient is required to complete Form 2.1 – Cancellation of Admission Certificates or Renewal Certificates.

Virtual Health

Assessments and examinations of persons in facilities may be done by video conference, provided the use of technology for the assessment and examination is reasonable in the circumstances (section 13.2 of the Act). Such examinations are already explicitly provided for in the CTO context; the above amendment expressly permits examinations using video conference for all examinations that take place at a facility.

Revised Criteria for Admission Certificates and Renewal Certificates

The criteria for admission and renewal certificates have been amended to provide that the person must be able to benefit from treatment for their mental disorder; and the person is within a reasonable time, likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder.

Reasonable Grounds

A formal patient may now only object to informing the patient's nearest relative of the reasons for issuance of certificates, etc., on "reasonable grounds". In other words, the formal patient must demonstrate to the board an objective reason to support not informing the patient's nearest relative.

- Similarly, formal patients may now object to a qualified health professional informing the patient's nearest relative on reasonable grounds for the purposes of a Form 11 - Certificate of Incompetence to Make Treatment Decisions and the notice of discharge (sections 27(3) and 32 of the Act).

Note: a formal patient does not require "reasonable grounds" to object to [sections 18(1) set out additional context and specific sections.]

Revised Responsibilities of Facility Leadership

Facilities that are designated in the regulations may be operated by AHS or Covenant Health. The Act refers to board responsibilities, and facility leadership assumes those responsibilities. Newly added responsibilities are listed here:

- Review Admission and Renewal Certificates (section 8.1 of the Act):

- The board must ensure admission and renewal certificates issued in respect of a person, are reviewed as soon as possible upon completion to ensure the form is complete, issued and provided to the person.

- Treatment Plans (section 9.01 of the Act):
  - The board shall ensure that a formal patient is provided with a written, individualized treatment plan within a month of their second admission certificate being issued.
  - There are specific elements that must be included in the treatment plan, including: the type of treatment expected to be provided, the criteria on which a formal patient would be released, and the criteria for privileges such as a leave of absence to be granted.
  - Treatment is defined as anything that is done for a therapeutic, preventative, or other health-related purpose, including the implementation of a treatment plan.
- Additional Duties Towards Patients (section 14 of the Act):
  - There is a requirement to inform formal patients of the right to counsel.
  - The written statement provided to the patient must also specify the steps for the patient to follow to obtain free legal services, the function of the Patient Advocate, patients' rights to contact the Patient Advocate, and the right to obtain timely and free access to medical records for the purposes of a hearing before a review panel or appeal to the Court of King's Bench.
  - The board shall inquire with the formal patient to determine whether the patient wishes to be contacted by the Patient Advocate, and, if so, the board shall notify the Patient Advocate and provide a copy of the admission/renewal certificates and a summary of the information provided to the formal patient under section 14 of the Act.
- Access to Records (section 14(6) of the Act):
  - When a formal patient applies to the review panel or to the Court of King's Bench, the board shall provide the patient a copy of the relevant medical records in advance of the hearing or appeal, free of charge and as soon as practicable.

- Form 6 - Memorandum of Transfer to Another Facility (section 22(1.1) of the Act):
  - Form 6 - Memorandum of Transfer to Another Facility is no longer required to transfer a formal patient between two facilities operated by a single regional health authority, or between two facilities operated by a contracted service

provider of a regional health authority. This form needs to be completed only when a patient is being transferred from

(a) a designated AHS facility to the Grey Nuns Community Hospital, Misericordia Community Hospital or Villa Caritas, or

(b) the Grey Nuns Community Hospital, Misericordia Community Hospital or Villa Caritas to a designated AHS facility.

New Reporting Requirement

AHS shall, on an annual basis, provide the Minister of Health a written report assessing the completion, accuracy and use of admission certificates and renewal certificates, as well as any other matter requested by the Minister. The Minister may also request a report on another basis or schedule (section 49.1 of the Act).

Community Treatment Orders (CTOs)

- CTOs may be issued where a person is likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder (section 9.1(b)(iii) of the Act).
- Individuals may now apply to a review panel for an order that the board issue a CTO (section 38(1)(b) of the Act).
- The timelines between two qualified health professionals completing separate examinations and issuing a CTO renewal has increased from 72 hours to 7 days (section 9.3(4) of the Act). Timelines for the initial CTO issuance remain unchanged.
- Amendments to the Community Treatment Order Regulation reflect the amendments to the CTO provisions in the Act.
  - Examination by video conference is expressly permitted for the purposes of renewals under section 9.3 of the Act (section 2 of the Community Treatment Order Regulation).
  - The regulation reiterates that when a review panel makes an order for a board to issue a CTO in respect of a formal patient, the CTO is to be issued in a reasonable amount of time in accordance with section 9.1 of the Act (section 2.1 of the Community Treatment Order Regulation).
  - The nearest relative of a person subject to a CTO is now prescribed by the regulation as a person to whom a written statement (first page of Forms 19, 20 and 21) and copy of an issued, amended, or renewed CTO must be given under section 14(1.1) of the Act, unless the person objects on reasonable grounds (section 7(3) of the Community Treatment Order Regulation).

Mental Health Review Panels (review panels)

- A review panel may order a further psychiatric assessment and examination of the formal patient or person subject to a CTO for the purpose of informing its decision on an application (section 40.1 of the Act).
- Individuals may now apply to a review panel for an order that the board issue a CTO (section 38(1)(b) of the Act).
- Individuals now have 30 days, instead of 14 days, to appeal a review panel's order to the Court of King's Bench (section 43(1) of the Act).

Mental Health Patient Advocate (Patient Advocate)

Additional responsibilities are outlined for the Patient Advocate including but not limited to: a) contacting formal patients who have asked to be contacted; b) providing information to formal patients, formal patients' guardians; and c) ensuring all information required to be provided by the board was provided (section 45(1.1) of the Act).

The Mental Health Patient Advocate Regulation, AR 148/2004 is repealed and replaced by Mental Health Patient Advocate Regulation, AR 173/2020.

- An investigation may now be initiated by the Patient Advocate into any matter under the Act relating to a patient, with or without the patient's consent (section 4(1) of the Mental Health Patient Advocate Regulation).
- Previously, without the patient's consent, the Patient Advocate could only initiate an investigation into various procedures of a facility (e.g., procedures related to the admission of persons detained under the Act, procedures for informing patients of their rights, etc.).
- If the Patient Advocate determines it is more appropriate for an investigation to be carried out by another committee, body, person or entity, the Patient Advocate may refuse to investigate or cease to investigate a matter (section 9(1)(d) of the Mental Health Patient Advocate Regulation).
- The Patient Advocate may request in writing from the facility, board, regional health authority or "issuing qualified health professional" any policy, directive, medical record, or other record relating to a patient subject to an investigation or to whom an investigation relates, and the documents requested must be provided to the Patient Advocate within a reasonable time (section 11 of the Mental Health Patient Advocate Regulation). The "issuing qualified health professional" is defined to mean the qualified health professional who last issued, renewed, or amended a CTO or issued an apprehension order (section 1(c) of the Mental Health Patient Advocate Regulation).

Protection of Individual Rights within the *Mental Health Act*

Whether an individual is involuntarily admitted or issued a CTO, the Act protects their rights by identifying what those rights are and directing that those rights 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, the right to notify others about their detention, and the right to apply to a review panel to review or cancel certificates and CTOs. Patient rights also include the right to access legal counsel and the right to appeal review panel decisions to the Court of King'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 right to contact the Patient Advocate for rights information, support and to investigate concerns or a complaint.

Protection of patient rights goes hand in hand with treating the patient respectfully. Care and treatment not only provide safety in times of crisis but also reflect ongoing compassion for the patient and their circumstances. Finally, healthcare professionals and mental health service providers should involve the patient in treatment planning to the extent possible, offering the patient support for recovery and hope for the future.

This 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 (Chapter 7),
- confidentiality and access to health information (Chapter 8), and
- the 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) of the Act). When the Act imposes a duty on or grants a power to the "board", in practice this has likely been delegated to an 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.

CHAPTER 1: Designated Facilities

This chapter will cover

- what are facilities,
- who can be admitted to a designated facility,
- how forensic patients are admitted to designated facilities,
- how to manage a complaint at a designated facility, and
- responsibilities of the board/facility leadership.

1.1 Introduction to Facilities

Definition of facilities

Facilities are places (or parts thereof) that have been **designated** in the Mental Health Act Forms and Designation Regulation as 'facilities' for the purpose of the Act. In practice, the term "designated facilities" refers to inpatient health facilities which have been authorized by the Minister of Health as the only places that can admit and detain formal or involuntary patients under the Act. There are many healthcare facilities in Alberta but only a limited number are designated facilities. A list of designated facilities as of December 2021 is in Appendix II (section 15.2 of the Mental Health Act Forms and Designation Regulation, Alta Reg 136/2004).

In the Mental Health Act Forms and Designation Regulation, three types of facilities are listed, however throughout this guide any references to "facility" will refer to the ones listed in 15.2(1), not necessarily to sections 15.2(2) and (3).

- Section 15.2(1) of the Mental Health Act Forms and Designation Regulation are designated as facilities for the purposes of section 1(1)(d) of the Act.
- Section 15.2(2) of the Mental Health Act Forms and Designation Regulation are designated as facilities for the purposes of section 1(1)(d) of the Act, only for the purposes of section 13 of the Act.
- Section 15.2(3) of the Mental Health Act Forms and Designation Regulation are designated as facilities for the purposes of section 1(1)(d) of the Act, except for the purposes of sections 4(1)(a), 9.6, 10, 12 and 24 of the Act. Voluntary Patients in Designated Facilities

1.2 Voluntary Patients in Designated Facilities

Designated facilities may admit patients 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.
>
> In the course of the assessment interview with the physician and healthcare team, the person and/or family member relays changes in the way the person 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 the local emergency department for follow-up treatment in the community, and/or continue seeing their family physician or psychiatrist. If admitted voluntarily, the patient would be able to discharge themselves at any time.

1.3 Formal Patients in Designated Facilities

A person becomes a formal patient when admitted involuntarily and detained in a designated facility by the issuance of two admission or renewal certificates. Qualified health professionals are guided by the Act, which contains the criteria that must be met in order to involuntarily detain a person in a designated facility.

1.4 Minors in Designated Facilities

The Act makes no age distinctions regarding detention in designated facilities. In Alberta, a minor (defined as anyone under the age of 18 years in section 28(1)(ii) of the *Interpretation Act*) as well as adults may be admitted as formal patients when they meet the **four** criteria for admission under the Act.

In addition, 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 can be 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 15.2(2) of the Mental Health Act Forms and Designation Regulation) (see Appendix III).

1.6 Managing Complaints arising within a Designated Facility

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 process 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 Relations Department within AHS or Covenant Health. In addition, patients under one or two admission or renewal certificates, or those acting on their behalf, have access to the Patient Advocate for information, support, or investigation of complaints.

As well, the Office of the Alberta Ombudsman and Protection for Persons in Care are able to conduct investigations concerning designated facilities (see Appendix IV).

1.7 Responsibilities of the Board / Facility Leadership

The board or facility leadership has been given a number of responsibilities under the Act, including the ones noted in the chart below.

MHA Section	General Area	Duty of the Board / Facility Leadership
1(1)(h)(ii)	Designation of “nearest relative”	The board may designate in writing any adult person to act as the nearest relative if there is no nearest relative within any description in subclause (i) of the definition (e.g., family member) or if, in the opinion of the board, the nearest relative determined under subclause (i) would not act or is not acting in the best interest of the formal patient or the person who is subject to a community treatment order.
5(1)	Examination of person detained	When a person is conveyed to a facility under section 10 of the Act (warrant for

MHA Section	General Area	Duty of the Board / Facility Leadership
		apprehension by a provincial court judge), section 12 of the Act (apprehension by a peace officer) or section 24 of the Act (transfer into Alberta),or is detained in a facility pursuant to one admission certificate, the board of the facility shall ensure that the person is examined as soon as possible by a qualified health professional.
8.1	Review and provision of admission certificates, renewal certificates	The board must ensure admission and renewal certificates issued in respect of a person are reviewed as soon as possible upon completion to ensure the form is complete, issued and provided to the person.
9.01	Treatment Plan	The board shall ensure that a formal patient is provided with a written, individualized treatment plan within a month of their second admission certificate being issued. There are specific elements that must be included in the treatment plan, including: the type of treatment expected to be provided, the criteria on which formal patient would be released, and the criteria for privileges such as a leave of absence to be granted. Treatment is defined as anything that is done for a therapeutic, preventative, or other health-related purpose, including the implementation of a treatment plan (section 1(1)(p.2) of the Act).
14(1)(a)	Duties toward patients – Information	When two admission or renewal certificates are issued with respect to a patient, the board must inform the formal patient and make a reasonable effort to inform the patient's guardian, if any, and, unless the patient objects on reasonable grounds, the patient's nearest relative, of (i) the reason, in simple language, for the issuance of the admission certificates or renewal certificates, (ii) the patient's right to apply to the review panel for cancellation of the admission certificates or renewal certificates or for an

MHA Section	General Area	Duty of the Board / Facility Leadership
		order for the board to issue a community treatment order, and (iii) the patient's right to legal counsel.
14(1)(b)	Duties toward patients – Written Statement	The board must give the formal patient, the patient's guardian, if any, one person designated by the patient, and unless the patient objects on reasonable grounds, the patient's nearest relative a written statement. The written statement must include the information specified in section 14(1)(a) of the Act. The written statement provided to the patient must also specify the steps for the patient to follow to obtain free legal services, the function of the Mental Health Patient Advocate (Patient Advocate), patients' rights to contact the Patient Advocate, and the right to obtain timely and free access to medical records for the purposes of a hearing or an appeal.
14(1)(c)	Duties toward patients – Copies of Documents	The board must provide the patient, the patient's guardian, if any, one person designated by the patient and, unless the patient objects on reasonable grounds, the patient's nearest relative with copies of the admission certificates or renewal certificates, and a summary of the assessment made of the patient's competence to make treatment decisions.
14(1)(d)	Duties toward patients – Contact by Mental Health Patient Advocate	The board must inquire with the formal patient to determine whether the patient wishes to be contacted by the Patient Advocate, and, if so, the board must notify the Patient Advocate and provide the Patient Advocate with a copy of the admission/renewal certificates and a summary of the information provided to the formal patient under section 14 of the Act.
14(2)	Duties toward patients – Interpreter	In the event of language difficulty, the board must obtain a suitable interpreter and provide the information and the written statement referred to in section 14(1) of the Act in the

MHA Section	General Area	Duty of the Board / Facility Leadership
		language spoken by the formal patient or the patient's guardian.
14(3)	Duties toward patients – Facilitate application	In addition to giving a written statement pursuant to section 14 of the Act, the board shall do any other things the board considers expedient to facilitate the submission of an application to the review panel.
14(4)	Duties toward patients - Information for person designated by formal patient	If a formal patient has designated another person to receive notices, the board shall also mail a copy of all notices and information required to be given to the patient to the person designated at the address provided by the patient.
14(6)	Duties toward patients - Provision of Medical Records	When a formal patient applies to a review panel or the Court of King's Bench, the board shall provide the patient a copy of the relevant medical records in advance of the hearing, free of charge and as soon as practicable.
18(1)	Refusal of Admission to facility – Provision of Information	When any person is conveyed to a facility pursuant to one admission certificate and another admission certificate is not issued with respect to that person, the board shall inform the person and, if the person does not object, the referring source, of the reasons why another certificate was not issued and may refer the person to another facility or service, in which case the referring source shall, unless the person objects, be informed of any alternative arrangements made.
19(1)	Treatment and Security of Patients – Provision of Diagnostic and Treatment Services	On the admission of a patient to a facility, the board of the facility shall provide the diagnostic and treatment services that the patient is in need of and that the staff of the facility is capable of providing and able to provide.
19(2)	Treatment and Security of Patients – Level of Security	The board of a facility in which a formal patient is detained shall determine what level of security is reasonably required for each patient in view of all the circumstances and afterwards provide it and review the

MHA Section	General Area	Duty of the Board / Facility Leadership
		necessary level of security at intervals of not more than three months.
20	Leave of Absence	The board may grant a formal patient a leave of absence from the facility on any terms and conditions prescribed by the board. The board may by notice in writing revoke the leave of absence and recall the patient. Where the formal patient refuses or neglects to return to the facility or when the board is unable to serve a notice in writing, the board may declare the person to be absent without leave and issue an order ordering any peace officer to return the patient to the facility.
22	Transfer to Another Facility	A board may, if otherwise permitted by law and arrangements have been made with the board of another facility, transfer a formal patient to that facility on completing Form 6 – Memorandum of Transfer to Another Facility. Form 6 - Memorandum of Transfer to Another Facility is not required to transfer from an AHS facility to AHS facility, or from a Covenant Health facility to a Covenant Health facility but continues to be required to transfer between an AHS facility and a Covenant Heath facility.
23(1)	Transfer for hospital treatment	When a formal patient requires hospital treatment that cannot be provided in the facility, the board may, if otherwise permitted by law, transfer the patient to a hospital for treatment and return the patient to the facility on the conclusion of the treatment.
27(3)	Competence to make Treatment Decisions – Provision of Information	The board shall give to the formal patient, the patient's agent, if any, the patient's guardian, if any, and, unless the patient objects on reasonable grounds, the patient's nearest relative a copy of the certificate and written notice 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 a notice of application to the chair of the review panel in the prescribed form.

MHA Section	General Area	Duty of the Board / Facility Leadership
31(1)	Cancellation of certificates	A board must comply with and take any action necessary to comply with a decision of a review panel concerning admission certificates or renewal certificates.
32(1)	Notice of Discharge	When a patient is discharged from a facility, the board shall, where reasonably possible, give notice of the discharge (a) to the patient's guardian, if any, (b) to the patient's nearest relative, unless the patient being discharged objects on reasonable grounds, and (c) to the physician or nurse practitioner who treats the patient in their ordinary day-to-day health care needs, if known, along with the discharge summary, including any recommendations for treatment, and, when applicable, shall state in the notice whether a certificate of incapacity is in effect under the *Public Trustee Act* with respect to the patient.
41(1)	Decision of review panel	A review panel may order the board to issue a community treatment order (CTO) in respect of a patient within a reasonable amount of time.
42(1)	Onus in review panel or Court of King's Bench hearing	In a hearing before a review panel or the Court of King's Bench, the onus is on the board of the facility in which the patient is detained to show that (a) detention is required, and the patient meets the criteria referred to in sections 2 and 8(1), (b) the physician's opinion under section 27 is correct, (c) it is in the best interest of the formal patient to administer treatment in accordance with section 29, or (d) the patient should not be returned to a correctional facility under section 33, as the case may be.

CHAPTER 2: Apprehension and Conveyance to a Designated Facility; Detention in a Designated Facility

This chapter will cover

- how to access an examination by a qualified health professional under the Act,
- how a Provincial Court judge, peace officer and qualified health professional facilitate apprehension and conveyance of a person, including someone not complying with a CTO, to a designated facility,
- what criteria are 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 a qualified health professional's examination and detention under one admission certificate at the designated facility,
- what rights a person has when one admission certificate is issued, and
- questions related to apprehension, conveyance, and detention in practice.

2.1 Apprehension, Conveyance and Detention

The terms apprehension, conveyance and detention are used in the Act to describe the process of seeking out and taking a person to a designated facility for examination by a qualified health professional. The person can be detained under the Act, and the examination must be conducted as soon as possible (section 5(1) of the Act).

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 they meet 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 qualified health professional 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 apprehended and 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),
- Form 3 – Order to Return a Formal Patient to a Facility (section 20(4) or 21(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 (Form 1 - Admission Certificate)

The initial assessment may occur in the community (e.g., a physician's office) where the qualified health professional 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 to a designated facility. In most situations a person will be brought by family or friends, or by Emergency Medical Services, especially in situations where medical support is required. A peace officer may also bring a person to a designated facility for further examination.*

If the admission certificate is completed on the unit or in the emergency department of a designated facility, the Act permits the person to be detained for a specified amount of time in order that activities prescribed under the Act may take place.

Four criteria for admission certificate

In order to complete a Form 1 - Admission Certificate the examining qualified health professional must believe that a person

- is suffering from mental disorder,
- has the potential to benefit from treatment for the mental disorder,
- is, within a reasonable time, likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder, and
- is unsuitable for admission to a facility other than as a formal patient.

All four 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 definition of mental disorder **"does not include a disorder in which the resulting impairment is persistent and is caused solely by an acquired or congenital irreversible brain injury".** The definitions of "irreversible brain injury" and "persistent" are set out in section 2.1 of the Mental Health Regulation as follows:

> *(a) "irreversible brain injury" means a permanent disruption to the baseline function of the brain or to the structure of the brain caused or likely caused by an identifiable or probable*
>
> *(i) acute external action, including trauma, or*
>
> *(ii) pathophysiological event within the body, including an acute hypoxic event, but does not include a permanent disruption caused or likely caused by a neurodegenerative disorder.*
>
> *(b) "persistent" means stable and unlikely to improve as a result of treatment.*

The meaning of the fourth 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 if admitted voluntarily (e.g., be at higher risk for suicide) or
- the person being examined may be considered to lack the mental capacity to understand and consent to admission and treatment.

Further, this fourth criterion may be met when a competent person – or an incompetent person's substitute decision-maker (SDM) – refuses to consent to that person being admitted to a facility to receive psychiatric treatment.

Timeframes for Examination by a Qualified Health Professional; Issuance of First Admission Certificate

A qualified health professional 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).

Once a Form 1 - Admission Certificate has been issued in the community, any person is allowed **72 hours** from the time the Form 1 - Admission Certificate is issued to apprehend the person named in the certificate and to care for, observe, assess, detain, control, and convey them to a designated facility (section 4 of the Act).

When a person is detained in a facility under a Form 1 - Admission 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 qualified health professional (section 5(1) of the Act).

> When assessing the patient's mental state, collateral information from family and friends, community healthcare workers, peace officers and members of the community may be taken into account. It must be noted on the Form 1 – Admission Certificate which facts were communicated by others.

Options following issuance of the first admission certificate

At least one of the admission certificates must be issued by a physician, and at least one of the admission certificates must be issued by a member of staff of the facility (section 7(2) of the Act).

If a second admission certificate is not issued 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, the person may remain as a voluntary patient. If the first admission certificate is issued at the designated facility, section 5 of the Act requires that both admission certificates be completed within **24 hours**.

2.3 Warrant for Apprehension Issued by a Provincial Court 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 suffering from a mental disorder stops taking prescribed medication, appears unable to care for themself, is having a recurrence of severe symptoms yet refuses to see a physician. This same

process can be followed if a person is known to be on a CTO and is not complying with it. See section 2.6 below for more details.

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 about where to go and how to bring a Form 7 - Information 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 mental disorder, and
- within a reasonable time, likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder (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 families and any other person appearing before a judge for this application may bring notes to which they can refer. As well as completing documents, the individual bringing the Form 7 – Information to the judge should expect to answer questions and discuss with the judge information related to the person's previous episodes of mental illness, any diagnoses, 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 a peace officer to apprehend the person named in the warrant, to care for, observe, assess, detain, and control while conveying the person to a designated facility for examination.

2.4 Extension of the Warrant (Form 9 - Extension of Warrant)

The warrant expires **7 days** after it is issued by the Provincial Court judge, unless it is extended under section 11 of the Act for a further **7 days** (section 10(7) of the Act). Such an extension is available only once.

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

- This application 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 must be filed with the clerk of the court.

2.5 Apprehension by a Peace Officer (Form 10 - Statement of Peace Officer on Apprehension)

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 suffering from a mental disorder and acting in a manner likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder.

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 designated facility for examination when they have reasonable and probable grounds to believe that a person

- is suffering from mental disorder, and
- is within a reasonable time, likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder, 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 imminent risk or extreme behaviours of the individual may justify immediate apprehension and conveyance to a hospital).

When assessing whether the person is suffering from a mental disorder for the purpose of section 12 of the Act, there is a presumption, in the absence of evidence to the contrary, that the resulting impairment is not persistent; not caused solely by an acquired or congenital irreversible brain injury; or not persistent and not caused solely by an acquired or congenital irreversible brain injury (section 2.2 of the Mental Health Regulation).

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

When the peace officer conveys the person to a designated facility, the peace officer must complete a statement using Form 10 – Statement of Peace Officer on Apprehension (section 11 of the Mental Health Act Forms and Designation Regulation). Required information includes the name of the person (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.

2.6 Apprehension and Conveyance of a Person not Complying with a Community Treatment Order (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 - Community Treatment Order Apprehension Order)

- completed and signed by a qualified health professional 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 - Community Treatment Order Apprehension Order 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 qualified health professional must indicate on the apprehension form a *specific facility* to which the person 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 - Warrant)

- issued when someone brings information under oath before a judge about a person subject to a CTO regarding their reasonable and probable grounds to believe the named person is not complying with their CTO (Form 7 - Information),
- if the judge believes that the person is not complying with their CTO, and an examination cannot be arranged in any other way, the judge may issue a warrant (Form 8 - Warrant),
- the warrant gives peace officers the authority to apprehend and convey the named person to a designated 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 - Extension of Warrant is used to extend the warrant.

3. By **acting pursuant to section 12(1) of the *Act* under peace officer discretion** (Form 10 - Statement of Peace Officer on Apprehension)

   In order to apprehend and convey, the peace 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 (i.e., judge's Warrant) would be dangerous.

2.7 Examination at a designated facility

As soon as practicable and at most within **72 hours** of being conveyed to a facility under Form 23 - Community Treatment Order Apprehension Order, Form 8 - Warrant or Form 10 - Statement of Peace Officer on Apprehension, the person subject to the CTO must be examined by **two** qualified health professionals, **one** of whom must be a psychiatrist. Under section 9.6(4) of the Act, the **two** qualified health professionals 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 (Form 24 - Community Treatment Order Examination on Apprehension).

2.8 Questions about Apprehension, Conveyance and Detention in Practice

1. **Is it legally permissible for a qualified health professional to examine a person at a designated facility by way of video conference in order to issue the first admission certificate under the Act?**

Yes. Assessments and examinations of persons at designated facilities may be done by video conference, provided the use of technology for the assessment and examination is reasonable in the circumstances (section 13.2 of the Act).

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

Yes. The Patient Advocate is able to investigate complaints and provide rights advice to patients who are or have been subject to one or two admission certificates.

3. **Can an admission certificate be issued for a person who is intoxicated or impaired by drugs or alcohol?**

Yes. When a qualified health professional believes the person they have examined meets **all four** criteria necessary for the issuance of an admission certificate, the qualified health professional can complete a first admission certificate and advise the person that they are being detained for up to **24 hours** from time of arrival at a designated facility.

> 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 them unsuitable for care except under the Act.

4. **Is a peace officer required to complete a Form 10 - Statement of Peace Officer on Apprehension when they bring a person believed non-compliant with a CTO to a designated facility for examination under the authority of a Form 23 - Community Treatment Order Apprehension Order or Form 8 - Warrant?**

No. Duplicate forms are not required. Each one of these three processes, whether Form 8 - Warrant (section 10), **or** Form 23 - Community Treatment Order Apprehension Order (section 9.6), **or** Form 10 - Statement of Peace Officer on Apprehension (section 12), 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.

5. **Is the peace officer required to leave the Form 10 - Statement of Peace Officer on Apprehension at the designated facility?**

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

6. **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 designated facility in order that the qualified health professionals (whether in the emergency department or an inpatient unit) can work in compliance with the timeframes provided in the Act. The **24-hour** timeframe 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).

7. **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 four** criteria for certification under the Act, they may be admitted as a formal patient. The revised definition of mental disorder specifies that it does not include a disorder in which the resulting impairment is persistent and is caused **solely** by an acquired or congenital irreversible brain injury.

8. **Who is responsible to repatriate the person following discharge at a facility?**

It is the responsibility of the designated facility where the person was conveyed for examination to repatriate them home if they are not admitted to the designated facility as a patient following examination.

CHAPTER 3: 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 and why treatment plans are developed
- 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 or renewal certificates,
- how formal patients may be granted a leave of absence while hospitalized,
- how formal patients are transferred between designated facilities,
- when notification of discharge from a designated facility is required,
- questions about admission and detention in practice, and
- a review of the Flowchart and Key Points for Formal Patient Certification.

3.1 Second Admission Certificate

Upon arrival at a facility, **two** qualified health professionals must examine a person and complete two admission certificates within **24 hours** of time, 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 - Admission Certificate), 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).

At least one of the admission certificates must be issued by a physician and at least one of the admission certificates must be issued by a member of the staff of the facility (section 7(2) of the Act).

> *In practice, a person may be admitted to an inpatient unit from the emergency department 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 second admission certificate is issued (section 7(1) 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 qualified health professional 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, unless the person objects, this information shall 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 qualified health professional who assessed the person will be most aware of the reasons for not issuing a second certificate and certifying a patient. It may be appropriate that the second qualified health professional communicate with the qualified health professional 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 business address of the qualified health professional signing the admission certificate,
- date and time when the qualified health professional's examination was conducted,
- facts for each of the following four criteria leading to the qualified health professional's opinion that the person
    - is suffering from mental disorder,
    - has the potential to benefit from treatment for the mental disorder,
    - is, within a reasonable time, likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder, and
    - is unsuitable for admission to a facility other than as a formal patient,

- name of place where the person was examined, or the location of the person who was examined if the examination takes place by video conference,
- name and address of the facility to which the person is to be conveyed to be examined, if the person is not in a facility,
- date and time the certificate was issued, and
- signature and printed name of the qualified health professional who performed the examination.

Certificates are to be reviewed for completion (section 8.1 of the Act). This requirement can be met by having a staff member (not required to be a physician or a nurse practitioner) at a designated facility review the certificates for completeness. At the time of this writing, completeness is considered to be legible information being present on all parts of the certificate where information is required.

3.3 How and Why Treatment Plans are Developed?

Section 9.01 of the Act sets out the requirements of the treatment plan, including that the individualized treatment plan must:

- be provided in written form no later than one month after the issuance of the 2nd Admission Certificate (Form 1),
- set out the type of treatment expected to be provided to the formal patient,
- set out the criteria to grant privileges and passes to the formal patient, and
- set out the criteria required to end status as a formal patient.

Alberta Health Services (AHS) has created the Treatment Plan for a Formal Patient for provincial use to meet the requirements of section 9.01 of the Act.

3.4 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** qualified health professionals, one of whom must be a psychiatrist and one of whom must be a member of the facility's staff, to separately examine the formal patient and issue a renewal certificate before the expiry date of the **second** admission certificate (section 8(2) of the Act). When the patient meets the criteria for continued certification the qualified health professionals may extend the term of detention by each issuing a renewal certificate within **24 hours** after their examination using Form 2 - Renewal Certificate (section 8(1) of the Act).

Criteria for renewal certificates

The **two** qualified health professionals must separately believe that the formal patient

- is suffering from mental disorder,
- has the potential to benefit from treatment for the mental disorder,
- is, within a reasonable time, likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder, and
- is unsuitable for admission to a facility other than as a formal patient.

Section 8(3) provides for use of renewal certificates (Form 2 - Renewal Certificate) 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).

3.5 Completion of Forms

The board must ensure admission and renewal certificates issued in respect of a person are reviewed as soon as possible upon completion to ensure the form is complete, issued and provided to the person (section 8.1 of the Act).

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. Healthcare providers may address specific questions to their organization’s internal legal services.

3.6 Admission and Detention Arising from an Arrest for Criminal Charges

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

- a person can be released outright or released on bail,
- 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 qualified health professional may believe that the person meets the requirements to be involuntarily detained in a designated facility, and may issue a first admission certificate. The person will then be conveyed to a designated facility, where they will be assessed by another qualified health professional for their 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 facility (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 they were originally incarcerated.
- Alternatively, the person may be admitted involuntarily pursuant to admission or renewal certificates and serve the remainder of their 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.

3.7 Application to Cancel Certification and Detention

Under the *Constitution Act, 1982*, a person has the right to a hearing to review their detention (Part I: *Canadian Charter of Rights and Freedoms*). Similarly, the Act is explicit about the right of the formal patient to apply for a hearing to review their detention and consider cancellation of admission or renewal certificates issued by the **two** qualified health professionals. For this reason, review panels accept applications from formal patients who are 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 or for an order for the board to issue a CTO (section 38), using Form 12 - Application for Review Panel Hearing.
- An automatic review of a formal patient's admission or renewal certificates occurs at or soon after **6 months** if no review has been applied for earlier (section 39 of the Act).
- A patient may apply to a review panel to be transferred back to a correctional facility (section 33), using Form 12 - Application for Review Panel Hearing. If the patient is a formal patient, the review panel will first need to decide whether to cancel the admission or renewal certificates.

3.8 Leave of Absence

During hospitalization formal patients may be allowed to spend time outside the facility. A treatment plan must set out the criteria on which privileges, including leaves of absence, would be granted (section 9.01(2)(c) of the Act). The treatment plan must be provided no later than **one month** after the issuance of a second admission certificate. A leave of absence

- may be granted based on terms and conditions, such as where patients will be staying and with whom, for what length of time, 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. These circumstances can include things like being with the family for a special occasion dinner, cleaning the patient's apartment or, looking for employment or a place to live. In practice, a qualified health professional writes an order for the leave of absence from a designated facility 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 the designated facility. 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 patient's hospitalization the duration of leaves may increase as the patient improves 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 a 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 - Order to Return a Formal Patient to a Facility to order a peace officer to return the patient to the facility (section 21(1) of the Act). Form 3 - Order to Return a Formal Patient to a Facility 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 - Order to Return a Formal Patient to a Facility

Peace officers are aided by knowing the physical description of the named patient, any characteristic mannerisms and identifying marks. They should also be told when the patient was last seen, what clothes the patient 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 patient named in the Form 3 - Order to Return a Formal Patient to a Facility.

3.9 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 they live in another province and are being taken to a facility closer to home. Each situation where a transfer may occur is outlined in the Act and may require the use of appropriate forms to maintain the authority of the *Mental Health Act* certificates in effect at the time.

Formal patients may be transferred

- to another designated facility (section 22(1.1) 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 - Certificate of Transfer into Alberta 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 - Transfer of Formal Patient to a Jurisdiction Outside Alberta (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.)

3.10 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 (section 31(2) of the Act).
- When a formal patient's admission or renewal certificates are cancelled or expire, the patient must be informed that they remain in the facility voluntarily (section 31(3) of the Act).
    - The patient may continue with mental health treatment as a voluntary inpatient, or if inpatient treatment is not required, the patient may be discharged.
    - A voluntary 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.

The physician who cancels admission certificates or renewal certificates due to the patient no longer meeting the criteria, must complete a cancellation certificate (Form 2.1 – Cancellation of Admission Certificate or Renewal Certificate, section 31(4) of the Act).

Notice of discharge

Upon discharge of formal patients, notification must be provided to the patient and, where reasonably possible, their

- guardian, if any,
- nearest relative, unless the patient objects on reasonable grounds,

- physician or nurse practitioner who treats the patient in their ordinary day-to-day health care needs, *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(2) and section 32(3) of the Act).

3.11 Questions about Admission and Detention in Practice

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) of the *Interpretation Act* 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 discharge summary provided to physicians and nurse practitioners and the timeframe within which this must occur?**

Section 32 of the Act states that discharge notices are provided to physicians and nurse practitioners who treat the patient in their ordinary day-to-day health care needs, if known, which will 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 physicians and nurse practitioners who treat the patient in their ordinary day-to-day health care needs 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. **Notice of discharge must be given to the patient's nearest relative unless the patient objects on "reasonable grounds." Does the Act give direction on what would be "reasonable grounds"?**

There is nothing specific in the Act. In general, the question of whether there are reasonable grounds involves both subjective and objective considerations. First, the patient may give reasons for their concerns. Second, consideration is given to whether it would be reasonable for a person in the patient's particular circumstances to object. To assist with this second consideration, is there information that can be ascertained by observation or through information received about or from the family that indicates that a reasonable person would refuse to disclose information in the patient's particular circumstances. Section 32 of the Act states that the board must give notice of discharge, and it is likely that the assessment of whether there are reasonable grounds will be delegated to a qualified health professional.

4. **When is a Memorandum of Transfer to Another Facility – Form 6 required?**

Section 22(1) of the Act and Form 6 - Memorandum of Transfer to Another Facility relate to the transfer from one facility to another; AHS zoning is irrelevant. A Form 6 - Memorandum of Transfer is required when a patient is being transferred from a designated AHS facility to either the Grey Nuns Community Hospital, Misericordia Community Hospital or Villa Caritas, or when the Grey Nuns Community Hospital, Misericordia Community Hospital or Villa Caritas transfer a patient to a designated AHS facility.

Use of a Form 6 is not required in situations where a detained person is transferred temporarily to a hospital for medical treatment. In these situations, the patient must be returned to the designated facility at the conclusion of the treatment (see section 23).

5. 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 SDM or is the SDM's original consent (as obtained by the referring facility) still valid?

The Act does not speak to this question. 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.

6. 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 or designate.

In Ministerial Order #614/2021, the Minister delegated the 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 as defined in the Mental Health Act with respect to persons 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 Addiction and Mental Health Services).

7. Can Protective or Security Services in an emergency department 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 protective services/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 protective services/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 protective 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*.

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

The physician who cancels a formal patient's admission certificates or renewal certificates must complete a cancellation certificate (Form 2.1 - Cancellation of Admission Certificates or Renewal Certificates, section 31(4) of the Act). Form 2.1 - Cancellation of Admission Certificates or Renewal Certificates requires the physician to document the reasons for the cancellation of the certificate based on the facts observed by the physician, and the facts communicated by others.

A Form 2.1 is not required when admission certificates or renewal certificates expire, or when a review panel cancels admission certificates or renewal certificates. As well, section 9.1(3) of the Act states that admission certificates or renewal certificates are cancelled on the issuance of a CTO. A Form 2.1 is not required in those situations.

9. 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* (Canada). Should an alleged offence 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.

10. When a formal inpatient is charged with a criminal offence 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 offence** (a criminal offence 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 offence 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 offence** (a criminal offence 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 offence occurred. The physician may give their 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. Are a formal patient's *Mental Health Act* certificates still valid when a facility has a photocopy of the certificate instead of an original?

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

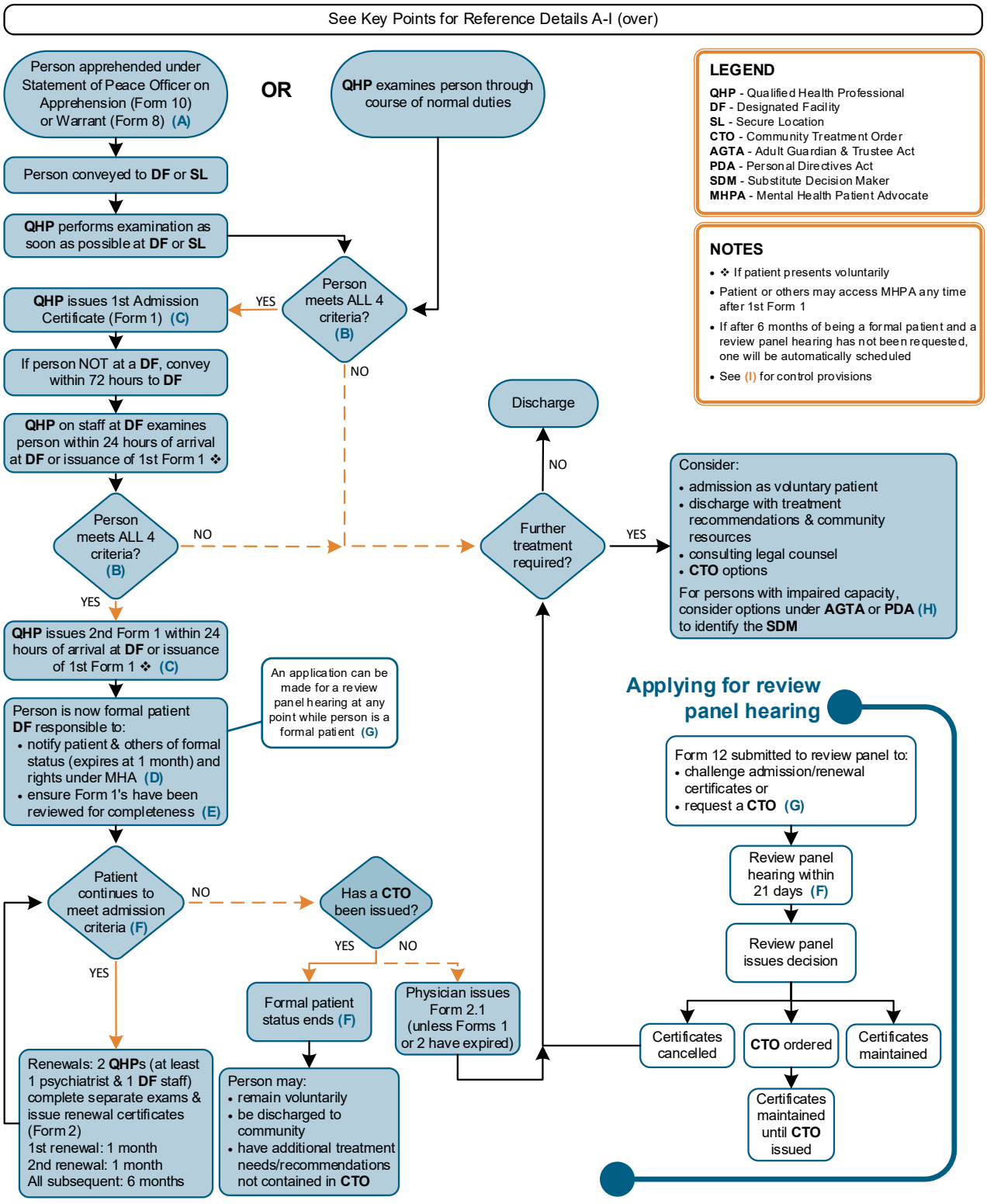
For the patient to be able to understand the reason for their detention and for the review panel, **legibility** of the certificate is a primary concern. In order to provide a fair hearing, the panel must be able to read the reasons for the issuance of any certificate. As examples

- "based on the following facts, observed by me, and/or communicated to me by others" are written by physician(s) on a certificate of mental incompetence to make treatment decisions,
- "the facts observed by me and/or communicated to me by others" provide reasons for a patient's detention under admission/renewal certificates,

12. "the facts on which I formed the above opinion" support the issuance of a community treatment order. **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. Without an original signature, there can be practical problems and/or evidentiary problems during a review panel hearing.

3.12 Flowchart: Formal Patient



October 2022

Alberta Health Services

Formal Patient Key Points

Mental Health Act (MHA) of Alberta

Definition of Mental Disorder (MHA s.1(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, but does not include a disorder in which the resulting impairment is persistent and is caused solely by acquired or congenital irreversible brain injury.

A. Apprehension by Warrant or Peace Officers Statement (MHA s.10/12)

To apprehend a person who requires examination, **Judge** or **Peace Officer** have grounds to believe:

I. A person is suffering from mental disorder **AND** within a reasonable time, likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, related to the mental disorder – **OR**

II. A person is not complying with their CTO.

Judge's Warrant: (Form 8)

- Anyone can submit a Form 7 to a judge at a provincial court with sworn information (see above: A.I. or A.II.)
- Only used if examination cannot be arranged through any other means.

Peace Officer's Power: (Form 10)

- Used if proceeding under a judges warrant would be dangerous.

B. Formal Patient Certification Criteria (MHA s.2)

1) Suffering from a mental disorder
2) Potential to benefit from treatment for the mental disorder
3) Within a reasonable time, likely to cause harm to others or to suffer substantial mental or physical deterioration or serious physical impairment, related to the mental disorder
4) Unsuitable for admission to DF other than as a formal patient

C. Admission/Renewal Certificates (MHA s.4/7/8)

Gives the authority to care for, observe, examine, assess, treat, detain & control the person.

Effect of One Admission Certificate

- Apprehend (if required) & convey person to DF (if not there already) w/in 72 hours of issuance.
- Valid up to 24 hours from person's arrival at DF if conveyed under authority of MHA, or from issuance of first Form 1 if presented voluntarily.

Effect of Two Admission Certificates

- Valid up to 1 month from date of second admission certificate.

Renewal Certificates

- Must be issued within 24 hours after exam.
- Both renewal certificates must be completed prior to expiry of existing certificates.

D. Notifying Patients & Others (MHA s.14(1))

Who to notify:

- Formal patient **(i) (ii)**
- Guardian* (if any) **(i) (ii)**
- Nearest relative* (unless patient objects on reasonable grounds) **(i) (ii)**
- One person designated by patient (if any) **(ii)**

* *Reasonable efforts* must be made to inform these people

What to include in the notification:

i: Using simple language, and an interpreter if required, review **reason for certificate issuance**, patient's right to apply to a **review panel** and patient right to have **legal representation**

ii: Provide:

- copies of admission/renewal certificates,
- summary of assessment of competency to make treatment decisions
- written statement with the following requirements:
  - ✓ reason for issuance, authority & duration
  - ✓ right to apply for a review panel hearing to appeal certificates, or to request a CTO be ordered
  - ✓ function & contact information of the review panels
  - ✓ patient's right to legal counsel & steps to obtain free legal services
  - ✓ function & ways to contact the MHPA
  - ✓ patient's right to free & timely access to patient records relevant to review panel or Court of King's Bench hearing

E. Completeness Review (MHA s.8.1)

Admission & renewal certificates must be reviewed to ensure all fields are completed. The process for meeting this requirement, including who is responsible, may vary by zone.

F. Additional Notification Considerations

- Notifying patient and others must be completed upon initial admission AND each subsequent renewal (see **D**).
- A written treatment plan is required to be provided to patient 1 month after admission as a formal patient. See section 9.01.
- Notice of discharge must be given to patient's guardian, if any, and nearest relative (unless patient objects on reasonable grounds).
- A discharge summary with treatment recommendations should be provided to the patient's regular health care providers.

G. Review Panels (MHA s.14 & 34-43)

- Composed of a chair or vice-chair (lawyers), a psychiatrist & a member of the public.
- The formal patient, or anyone on their behalf, may apply for a hearing via Form 12 to:
  - ➢ cancel admission/renewal certificates
  - ➢ request a CTO
  - ➢ overturn a physician's certificate of incompetence to make treatment decisions
- The formal patient has the right to legal representation at all review panel hearings
- Prior to a hearing, formal patient is entitled to free & timely access to patient records relevant to review panel.
- A board or attending physician may apply to review panel for a treatment order.
- Any decision or order of the review panel may be appealed to the Court of King's Bench.

H. Mental Capacity & Decision Making

All adults are presumption of competent. Admission as a formal patient does not change this presumption. If a patient is assessed to lack capacity, consider options under AGTA: https://www.alberta.ca/adult-guardianship.aspx
If a personal directive is in place, consider enacting it though a Schedule 2 or 3 form. See https://www.alberta.ca/personal-directive.aspx

The MHA addresses competency rather than capacity (s.26-27). See *Competency & Consent for Formal Patient Flowchart* for additional information.

I. Control Provisions (MHA s.30)

The MHA authorizes minimal use of reasonable force, by mechanical means or medication – without patient consent – as necessary to prevent serious bodily harm to the person or another. Means used must have regard for the physical and mental condition of the person.

Additional Information

- In addition to the prescribed MHA forms referenced, all providers are expected to follow professional standards and organizational guidelines for documentation.
- Formal Patient Certificates (admission/renewal) are cancelled on the issuance of a CTO (MHA s.9.1(3)).
- For additional information on CTO's: *Community Treatment Order – Issuance or Renewal Flowchart*
- Terms used in this documents are specific to the MHA. For definitions, see MHA s.1.

#Form Name	Completed by	NOTES:
1 Admission Certificate	2 QHP	1 must be a physician and member of the staff of the facility
2 Renewal Certificate	2 QHP	1 must be a psychiatrist
2.1 Cancellation of Admission Certificate or Renewal Certificate	Physician	
8 Warrant	Judge	
10 Statement of Peace Officer on Apprehension	Peace Officer	
12 Application for Review Panel Hearing	Formal Patient / SDM / QHP / Other	

All Mental Health Act forms can be found on the website: https://www.albertahealthservices.ca/info/Page1256.aspx

For additional information on the Mental Health Act please visit https://www.albertahealthservices.ca/info/mha.aspx
For any enquiries about these materials please email: MHAandCTO.Enquiries@ahs.ca

October 2022

CHAPTER 4: Rights of Formal and Voluntary Patients

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 a review panel to cancel their admission or renewal certificates, or for an order for the board to issue a community treatment order (CTO),
- how the Mental Health Patient Advocate (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* (*Charter*) 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 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 they are being held under the Act and for how long. An individual detained under one certificate is also advised of the right to counsel as this is a *Charter* right. The individual will be given contact information for the Patient Advocate. Neither the right to contact the Patient Advocate, nor the right to counsel, following the issuance of one admission certificate are governed by the Act, but both are important (in addition to advising of the reasons for detention). **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 at a designated facility beyond 24 hours.

4.1 Notification of Certification and Right to Hearing before Review Panel

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 the patient is given their copy).

Simple language is used to inform:

1) the formal patient, 2) the patient's guardian and, unless the patient objects on reasonable grounds, 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, or for an order for the board to issue a CTO, and
- the patient's right to legal counsel.

A written statement must also be given, and may 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 on reasonable grounds, 4) the patient's nearest relative.

In summary, this written information must include (section 14(1) of the Act)

- the reason, in simple language, for the issuance of the admission or renewal certificate,
- the authority for the patient's detention and the length of the detention,
- the function of review panels,
- the right to apply to the review panel for cancellation of the admission or renewal certificates, or for an order for the board to issue a CTO,
- the name and address of the chair of the review panel assigned to the facility where the patient is located,
- the patient's right to legal counsel,
- the steps for the patient to follow to obtain free legal services,

- the function of the Patient Advocate,
- the patient's right to contact the Patient Advocate, and the mechanisms for making that contact, and
- the patient's right to obtain free and timely access to the patient's medical records relevant to a hearing before a review panel or the Court of King's Bench.

The board must also provide 1) the formal patient, 2) the patient's guardian, 3) one person designated by the patient and, unless the patient objects on reasonable grounds, 4) the patient's nearest relative with copies of the admission certificates or renewal certificates, and a summary of the assessment made of the patient's competence to make treatment decisions.

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, Legal Counsel, and the Mental Health Patient Advocate

All patients have the right to

- send and receive written 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 qualified health professional considers that a visitor would be detrimental to the patient's health (section 16(1) of the Act),
- visits from legal counsel at any time (section 16(2) of the Act), and
- contact the Patient Advocate for information, advice or to lodge a complaint.

4.3 Right to Treatment and a Treatment Plan

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).

The board must ensure that a formal patient is provided with a written individualized treatment plan not later than one month after the issuance of a second admission certificate (section 9.01(1) of the Act). The treatment plan must set out

- the type of treatment expected to be provided to the formal patient,
- the criteria on which release of the formal patient would be granted, and
- the criteria on which privileges, including leaves of absence, would be granted.

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, their agent, guardian, or nearest relative can consent or refuse to consent to a specific treatment on the formal patient's behalf (section 28 of the Act). That treatment should not be given until consent has been received from the patient or the patient's SDM. If a formal patient who is mentally competent or their SDM objects to any treatment the patient is receiving or will receive, a qualified health professional must not administer the treatment unless a review panel makes a treatment order (section 29(1) of the Act, Form 15 – Decision of Review Panel Regarding Treatment).

4.5 Control

Admission certificates and renewal certificates provide the authority to control the person named in the certificates (sections 4(1), 7(1), 8(3), and 23(2) of the Act). The authority to "control" is also provided by Forms 4, 8, 10, 23, and the authority also is shared when the patient is transferred to a hospital for medical treatment (section 23(2)).

Section 30 of the Act stipulates that the authority to control a person under the Act without the person's consent is only 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 an SDM), 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 requirement 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 **three** people with knowledge in the application of the *Mental Health Act*. When a formal patient applies to a 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 to request that

- admission certificates or renewal certificates be cancelled, or the board be ordered to issue a CTO (sections 14(1), 38(1) and 41(1) of the Act). The formal patient's agent, guardian, or another person may make this application on the formal patient's behalf.
- 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's agent or guardian may make this application on the formal patient's behalf.

Making an application on another person's behalf implies:

- The person is aware of the application and supportive of it being made on their behalf
- There is a practical reason the person is not making their own application (e.g., paranoia as a result of the mental disorder, inability to hold a pen, etc.)

In a hearing, the formal patient and their representative (e.g., the patient's legal counsel) have the right to be 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). All proceedings of the review panel must be conducted in private, and no other person has the right to be present without the prior consent of the chair of the review panel (section 37(2) of the Act). Members of the treatment team may be present to provide information at the review panel hearing, or to provide support to the patient.

4.8 Right to Appeal to Court of King's Bench

A patient may appeal any decision to the Court of King's Bench. This would typically happen if the patient is unsuccessful in challenging admission or renewal certificates or a certificate of incompetency to make treatment decisions before the review panel. The appeal is a rehearing of the matter on the merits (section 43(4) of the Act). The appeal must be commenced within 30 days after the receipt of an order or a written decision of a review panel (section 43(1) of the Act).

4.9 Questions about Rights of Formal and Voluntary Patients in Practice

1. **What written information is staff obliged to give the formal patient regarding the review panel?**

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.

The Act requires that formal patients be given additional information in writing, including the function of the review panel, the name and address of the review panel chair, the right to apply to the review panel for cancellation of admission certificates or renewal certificates or for an order for the board to issue a CTO, as well as a statement the patient has the right to obtain free and timely access to the patient's medical records relevant to a hearing before a review panel.

> *It is good practice for clinicians to provide formal patients, guardians, agents, and nearest relatives with fact sheets on formal patients, review panels and Legal Aid. Alberta Health Services has created the Written Statement of Certification and Acknowledgment of Notification/Patient Rights and the Formal Patient Information Sheet to meet these requirements. These resources, as well as additional written material on CTOs and the role of the review panel with CTOs are available on Alberta Health Services Insite and are available for use by Alberta Health Services and Covenant Health staff.*

A. **Are there additional Resources available?**

The following fact sheets are also available for downloading:

1. *Mental Health Act Information for formal patients*

   https://open.alberta.ca/publications/mental-health-act-information-for-formal-patients

2. *Mental Health Act Information about mental health review panels*

   https://open.alberta.ca/publications/mental-health-act-information-about-mental-health-review-panels

3. *Mental Health Act Information for persons subject to a community treatment order*

   https://open.alberta.ca/publications/mental-health-act-information-for-persons-under-community-treatment-order

B. The Patient Advocate provides brochures *Your rights under the Mental Health Act: One Admission Certificate;* and *Your rights under the Mental Health Act: Formal Patient*

C. Legal Aid Alberta provides legal services for mental health matters. Their website is located here: https://www.legalaid.ab.ca/services/mental-health-law/

D. *Mental Health Act* forms, including Form 12 - Application for Review Panel Hearing are available on the AHS website: https://www.albertahealthservices.ca/info/page1256.aspx

2. 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.

3. Why is it important for a 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 Act, that review of detention takes the form of a review panel hearing.

4. What if the patient does not understand their rights when they are 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 information about their rights 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 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) of the Act requires that information 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 on reasonable grounds, their nearest relative. This helps ensure that others are aware of the patient's rights and can advocate on their behalf if necessary.

5. Do formal patients who are minors have the same rights as other formal patients?

Yes. The Act makes no age-based distinctions regarding rights of formal patients.

CHAPTER 5: Mental Health Review Panels

This chapter will cover

- who sits on a review panel and what is its purpose,
- who can apply,
- 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* (*AGTA*) 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 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 three members: a chair or vice chair (who must be a lawyer), a psychiatrist, and a member of the general public (section 34(4) of the Act). Although the Act requires the Minister to appoint members of the review panel, the review panel operates independently from the Minister and the Department of Health when executing the functions under the Act.

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:

- objection to treatment (section 29(2) of the Act). The review panel's decision is noted on Form 13 - Notice of Hearing Before Review Panel.
- to cancel admission certificates or renewal certificates (section 38(1) of the Act). The review panel's decision is noted on Form 17 - Decision of Review Panel Regarding Admission Certificates, Renewal Certificates or Community Treatment Orders.

- to cancel a CTO (section 38(1.1) of the Act). The review panel's decision is noted on Form 17 - Decision of Review Panel Regarding Admission Certificates, Renewal Certificates or Community Treatment Orders.
- to ask for a review of a physician's opinion that the formal patient is not mentally competent to make treatment decisions - Form 11 - Certificate of Incompetence to Make Treatment Decisions (section 27(3) of the Act). The review panel's decision is noted on Form 14 - Decision of Review Panel Regarding Mental Incompetence to Make Treatment Decisions.
- to transfer a person back to a correctional facility (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 noted on Form 16 - Decision of Review Panel Regarding Transfer Back to a Correctional Facility.
- to order the board of the facility to issue a community treatment order in respect of a formal patient within a reasonable amount of time (section 38(1) of the Act). The review panel's decision is noted on Form 17 - Decision of Review Panel Regarding Admission Certificates, Renewal Certificates or Community Treatment Orders or Form 17.1 - Decision of Review Panel Regarding Order for the Board to Issue a Community Treatment Order.

Applications to review panels from physicians

- Physicians may also apply to a review panel (using Form 12 - Application for Review Panel Hearing) to order treatment that the physician believes is in the patient's best interests (section 29 of the Act) where a mentally competent formal patient refuses to consent to treatment, or
- where an individual who has legal authority (SDM) to make treatment decisions for an incompetent formal patient refuses to consent to treatment.

The application process

The patient or the person subject to a CTO has the right to apply to a review panel. In some circumstances, another person (such as a relative, guardian or agent) may also apply on their behalf (section 38(1) of the Act). Some applications must be made by the patient and cannot be made by another person on their behalf (section 27(3) and section 33(1) of the Act.) When advised that the patient/representative intends to apply to a review panel, the Act directs the board or qualified health professional 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 (section 40(4) of the Act) unless the application is to ask for a review of a physician's opinion that a formal patient is not mentally competent to make treatment decisions or for an order directing treatment to a competent patient who objects. In those circumstances, a hearing must be held within **7 days** of the chair receiving the application (section 40(3) of the Act). Using Form 13 - Notice of Hearing before Review Panel, the review panel chair replies to the patient/representative applicant giving written notice of the date, time, and place of the hearing. The chair of a review panel must give at least **7 days**' notice of the date, time, place, and purpose of the following of hearings (section 40(1) of the Act):

- to cancel admission certificates or renewal certificates (section 38(1) of the Act)
- to cancel a CTO (section 38(1.1) of the Act)
- to transfer a person back to a correctional facility (section 33 of the Act)
- to order the board of the facility to issue a community treatment order in respect of a formal patient within a reasonable amount of time (section 38(1) of the Act)

The chair of a review panel must give **reasonable notice** of the date, time, place, and purpose of the following hearings (section 40(2) of the Act):

- to ask for a review of a physician's opinion that the formal patient is not mentally competent to make treatment decisions (section 27(3) of the Act)
- a physician's application for a treatment order (section 29 of the Act)

Safeguarding the Rights of the Patient Appearing before a Review Panel

Information Provided to the Patient

When two admission certificates or two renewal certificates are issued with respect to a patient, the board is required to provide certain information to the patient as well as make a reasonable effort to inform the patient's guardian, if any, and unless the patient objects on reasonable grounds, the patient's nearest relative. The information that must be provided includes the patient's right to apply to the review panel for cancellation of the certificates or for an order for the board to issue a CTO, and the patient's right to legal counsel. This must be accompanied by a written statement setting out information

including the function of review panels, the name and address of the chair, the right to apply to the review panel for cancellation of the certificates or for an order for the board to issue a CTO, the patient's right to legal counsel, and the steps for the patient to follow to obtain free legal services.

Right to Obtain Free and Timely Access to the Patient's Medical Records

The patient has a right to obtain free and timely access to medical records relevant to a hearing before a review panel (section 14(6) of the Act). The patient does not need to make a request for medical records.

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 of the Act). 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 qualified health professional or other health services provider who is treating or who has treated the person appearing before the review panel, or
- legal counsel 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 (section 36(1) of the Act).

Format of Hearing

The patient must agree to the format for the hearing (section 37(2.1) of the Act). A review panel may conduct a hearing by any one of the following methods agreed to by the patient and chair of the review panel: in person, by telephone, by video conference or any other means of telecommunication.

5.3 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 legal counsel or agent) have the right to attend when evidence is presented and to 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).

5.4 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.

5.5 Further Function of Review Panels – 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 a review panel for a hearing if an application from the person or representative has not been made to the review panel within a period of time as set out below.

Formal Patients

Unless an application for review or an order for the board to issue a CTO has been made (and has not been 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'.

Regardless of the timelines for the deemed review hearings, a patient can apply for a review panel hearing at any time.

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 **second** renewal and every **second** renewal thereafter (i.e., every year) unless an application has been made in the month preceding the renewal (section 39(2) of the Act).

Regardless of the timelines for the deemed review hearings, a person subject to a CTO can apply for a review panel hearing at any time.

5.6 Appeal of Review Panel's Decisions

Any decision of a review panel may be appealed to the Court of King's Bench.

- There are costs associated with filing the Court of King's Bench appeal.
- The appeal must be commenced by Originating Notice within **30 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 (section 43(4) of the Act).
- 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 a review panel be put into evidence along with any further evidence the Court considers necessary (section 43(4) of the Act).
- The order of the Court of King's Bench is final and not subject to appeal (section 43(5) of the Act).

5.7 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, they have 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?**

Yes, The Act specifies only a small number of reasons why a chair may refuse to hear an application (see section 38(4)),

- that the application is frivolous, vexatious, or not made in good faith, or
- that there has been no significant change in circumstances since the previous hearing by the review panel.

Regarding Consent to Release Health Information to Legal Counsel 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 legal counsel access to their health record for the purposes of the review panel hearing? Or is the guardian's consent required?

Provided the guardian has authority over legal matters, the formal patient cannot consent to the disclosure of their health information to their legal counsel. In these cases, consent from the patient's guardian is required.

If the guardian does not have authority over legal matters, then the formal patient can consent to the disclosure of their health information to their legal counsel.

Written consent from the patient or patient's guardian, as appropriate, should be obtained in accordance with the facility's policies regarding the disclosure of health information.

Regarding Right to Appeal Physician's Certificate of Incompetence

3. 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 the Court of King's Bench

4. **Can a formal patient with a guardian (under the AGTA) appeal review panel decisions to the Court of King'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 represented adult (as is often granted in guardianship orders), the patient no longer has this authority. Formal patients should seek advice from their legal counsel (e.g., Legal Aid) since counterarguments may exist.

5.8 Questions about Review Panels and Hearings in Practice

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. A review panel and board collaborate to provide this service.

2. **How does the formal patient or person subject to a CTO request Legal Aid assistance?**

Formal patients and people on a CTO have the right to speak to legal counsel. Legal counsel can explain options and give advice. A formal patient can speak to legal counsel from hospital and legal counsel is able to visit the patient anytime, as long it is safe to do so.

Legal Aid Alberta offers a free lawyer, called "duty counsel," to help patients at review panel hearings. Requests for duty counsel can be made when applying for a review panel hearing by checking the box to request free legal representation on the Form 12 application. Legal Aid Alberta can also be contacted at 1-866-845-3425 if the patient has any questions about Legal Aid Alberta's services.

Applications for legal counsel can be made directly to Legal Aid Alberta at the number above for the purpose of appealing a review panel's decision to the Court of King's Bench.

3. **Does the review panel have to give written reasons for their decisions?**

In certain circumstances, yes. A decision must be issued within 24 hours of hearing applications (section 41(2)(b) of the Act). The review panel **must** give written reasons for the decision if the review panel decides not to cancel admission or renewal certificates or a CTO (section 41(4) of the Act). The review panel **may** choose to give written reasons in other circumstances, such as refusal to cancel a Form 11 - Certificate of Incompetence to Make Treatment Decisions.

The Act does not specify the content of the written reasons. The common law (judge-made law) deals with administrative fairness and decision-making, and under it, written reasons should include:

- a reference to the legislation under which the review panel has the authority to act;
- the issues before the review panel and the main arguments put forth by the parties;
- the finding of facts on which the review panel based the decision; and
- the reasons and rationale for the decision(s) made by the review panel, making a connection between information presented and the conclusions reached.

4. Do patients need the assistance of legal counsel in order to exercise their rights before review panels? What assistance is provided by Legal Aid?

Patients do not need the assistance of legal counsel in order to exercise their rights before a review panel. However, Legal Aid Alberta provides duty counsel to assist patients because a hearing before a review panel affects a patient's Charter rights. Legal Aid Alberta has stated the following:

> *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 legal counsel 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 if safe to do so. 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 talk to the patient.*

5. Can healthcare providers contact legal counsel/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).

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

Section 14(6) of the Act provides that if a patient applies for a review the board **shall**, without charge and as soon as practicable, provide the patient with a copy of the patient's medical records in advance of the hearing before the review panel. The patient would be able to provide legal counsel with a copy of the patient's health record.

Alternatively, legal counsel representing the patient may obtain written consent from the patient or patient's substitute decision-maker for release of health information, in accordance with the facility's policies regarding the disclosure of health information.

7. **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. Section 14(6) of the Act stipulates that if a formal patient applies for a review panel hearing or files an appeal to the Court of King's Bench, the board must in advance of the hearing, as soon as practicable, and without charge provide the patient with a copy of the relevant medical records. This section prevails despite the provisions of the *Health Information Act*. If there are concerns about information that will be disclosed under this section, then advice should be sought from in-house legal services.

8. **At a review panel hearing, does the review panel have the right to access the original health record of a formal patient?**

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*.)

9. **What is the role of the patient's qualified health professional in a review panel hearing?**

   The qualified health professional will present their knowledge of the patient based on history, treatment, and assessment, and to provide observations of the patient's mental status, behaviour, risks, changes, improvement, or deterioration since hospitalization. Although this information will be in the health record as well, the onus of proof is on the board of the facility in which the patient is detained or on the qualified health professional who issued, amended, or renewed the CTO (section 42 of the Act). As such, at a review panel hearing the qualified health professional must

be prepared to speak to the criteria under the Act and show how the criteria apply in the particular circumstances before the review panel and should not rely on the review panel reading and considering the contents of the health record.

10. Do patients need the assistance of legal counsel in order to exercise their rights before the Court of King's Bench?

No; patients can represent themselves in appeals to the Court of King'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 King'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 King'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, they will have to pay the legal counsel's fees (as negotiated between the patient and legal counsel).

12. Does Legal Aid offer representation and/or assistance with costs to a formal patient requesting assistance with an appeal to Court of King's Bench?

This answer depends on the specific facts of each case. Appeals to the Court of King's Bench must be initiated within **30 days** after the receipt of an order or a written decision of a review panel (section 43(1) of the Act).

A patient who wants to appeal a decision from the review panel to Court of King's Bench may apply for Legal Aid representation/assistance by completing a formal application to Legal Aid. It is strongly recommended to apply as soon as possible if Legal Aid assistance is required.

Coverage by Legal Aid Alberta for a Court of King's Bench appeal is decided on the basis of merit. Determination of merit may require Legal Aid to contact any previous legal representation at the review panel related to the appeal to the Court of King's Bench. Financial evaluation may also preclude Legal Aid from providing assistance with an appeal to the Court of King's Bench.

A decision to refuse coverage by Legal Aid can be appealed by the patient. Legal Aid tries to proceed with that appeal process quickly and they quite often manage to make a decision on the appeal before the limitation date for filing with court of King's Bench.

13. Should staff advise AHS Legal Services when a formal patient or person subject to a CTO has initiated an appeal to the Court of King's Bench?

Yes. If staff receives filed court documents in relation to appeal or an individual indicates they have filed an appeal and would like to provide documents to AHS, then staff should contact AHS Legal Services for assistance.

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 a 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 **second** 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 section 9(1) of the Community Treatment Order Regulation, the issuing qualified health professional is responsible for notifying the review panel of approaching deemed applications. In practice notification to the review panel is provided by either the CTO coordinator or the CTO administrative support within the zone.

CHAPTER 6: Competence, Consent and Treatment Decisions

This chapter will cover

- why substitute decision-makers are necessary,
- how competence is determined,
- how competence, consent and treatment decisions related to minors and mature minors,
- what is meant by ‘best interests’ of the patient,
- when second opinions are required,
- when and why a treatment order is issued,
- why formal patients including minors who are formal patients 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, and
- a review of the Flowchart and Key Points for Formal Patient, Competency and Consent for Treatment Decisions.

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 (CTO). In other words, a person may meet the criteria for involuntary detention as a formal patient or issuance of a CTO and still be deemed to have the mental competency to make treatment decisions. In general, a competent patient or person subject to a CTO can consent to treatment on their own behalf. Patients are presumed to be competent until a determination is made that they are not competent to make treatment decisions.

If a patient is deemed by a physician to be not competent to make treatment decisions, consent is provided by a substitute decision-maker (SDM). 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 to make treatment decisions, or their SDM 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 formal patient who is competent to make treatment decisions or the SDM of a formal patient who is incompetent to make treatment decisions.

6.1 Competence

The Act identifies a person as mentally competent to make treatment decisions if they are 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).

Pursuant to the Act, an assessment of competency involves a two-part test. A person may be found not competent to make treatment decisions if they do not meet one or both parts of the test.

Case law is helpful in interpreting the two-part test in section 26 of the Act. In the leading decision on consent to treatment, Starson v Swayze, [2003] S.C.C. 32, the Supreme Court of Canada commented on the first part of the test as follows:

> *The person must be capable of intellectually processing the information as it applies to his or her treatment, including its potential benefits and drawbacks. Two types of information would seem to be relevant: first, information about the proposed treatment; and second, information as to how that treatment may affect the patient's particular situation. Information relevant to the treatment decision includes the person's symptoms and how the proposed treatment may affect those symptoms.*

The person must have the ability to process, retain and understand information related to the treatment decision.

The second component of the test is that the person be able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. In considering the second part of the test in Starson v Swayze, the Supreme Court of Canada commented that:

> *The patient must be able to acknowledge his or her symptoms in order to be able to understand the information relevant to a treatment decision. Agreement with a medical professional's diagnosis per se, or with the "label" used to characterize the set of symptoms, is not, however, required.*

The second part of the test for capacity will not be met where it is demonstrated that the person is unable to apply the information about the proposed treatment to their own circumstances.

The person does not have to *actually* understand the subject-matter and appreciate the consequences. The person must have the ability to understand the subject-matter and apply the relevant information to their 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 Minors and Mature Minors

Minors

A patient under the age of 18 years is presumed to be a minor patient without capacity. Section 28 of the Act speaks to where the patient or person is a minor or is not mentally competent, and how the decision will be made by a person who is apparently mentally competent, is available and is willing to make the decisions.

If the minor patient is not considered to be a mature minor, their legal representative may provide informed consent or refuse to provide informed consent to the treatment/procedure(s) for the minor patient. This is most often their legally identified parent or guardian.

Mature Minor

There are times when this presumption of a minor not having capacity to consent to treatment can be rebutted and the minor patient may be able to provide consent, if the minor patient is assessed and deemed a mature minor. In practice the outcome of the mature minor assessment shall be documented in the patient's health record.

Depending on the assessment of a minor, the "mature minor principle" may apply, allowing the minor to make treatment decisions on their own behalf. The "mature minor principle" was explained in the Supreme Court of Canada decision, *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181:

> *[46] The latitude accorded to adults at common law to decide their own medical treatment had historically narrowed dramatically when applied to children. However, the common law has more recently abandoned the assumption that all minors lack decisional capacity and replaced it with a general recognition that children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding. This is known as the common law "mature minor" doctrine. As the Manitoba Law Reform Commission noted, this doctrine is "a well-known, well-accepted and workable principle which . . . raise[s] few difficulties on a day-to-day basis" (Minors' Consent to Health Care (1995), Report #91, at p. 33). The doctrine addresses the concern that young people should not automatically be deprived of the right to make decisions affecting their medical treatment. It provides instead that the right to make those decisions varies in accordance with the young person's level of maturity, with the degree to which maturity is scrutinized intensifying in accordance with the severity of the potential consequences of the treatment or of its refusal.*

Healthcare providers are encouraged to contact in-house legal counsel or the Canadian Medical Protective Association, as appropriate, 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 the 2009 Supreme Court of Canada decision referenced above dealing with mature minors (paragraph 96):

- 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 their core values and beliefs?
- What is the potential impact of the adolescent's lifestyle, family relationships and broader social affiliations on their ability to exercise independent judgment?
- Are there any existing emotional or psychiatric vulnerabilities?
- Does the adolescent's illness or condition have an impact on their 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.

6.3 Consent

Healthcare providers should follow their facility's or organization's policy regarding obtaining consent from a patient or their SDM.

6.4 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, of the physician's determination of their mental incompetence to make treatment decisions, 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 - Certificate of Incompetence to Make Treatment Decisions).

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 to make treatment decisions,
- must be provided to the formal patient, their agent, guardian, if any, and (unless the patient objects on reasonable grounds) the patient's nearest relative, and
- notifies the formal patient that they have the right to have the physician's opinion about their competence reviewed by a review panel by sending a Form 12 - Application for Review Panel Hearing to the review panel chair.

Choosing a substitute decision-maker

After issuing the certificate of incompetence the physician must identify someone under section 28 of the Act 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.

6.5 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,
- adult formal 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 to make treatment decisions, 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 available agent, guardian or nearest relative, the Public Guardian.

Requirements of the substitute decision-maker (SDM)

In order to act as the SDM, who is not the guardian or public guardian, 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 being made by the SDM, who are not the guardian or public guardian, 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.

A SDM will consider all four and may still make a different treatment decision than the treating physician. The board is not able to disqualify a SDM to find one that is more amenable. Instead, if warranted, a section 29 treatment order may be issued.

In practice, an SDM 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 their relationship with the patient.

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

If the formal patient makes an application to a review panel 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 regarding mental competence pending the outcome of the application (section 27(4) of the Act). This means if a patient objected to a treatment, that treatment cannot happen until after a review panel has issued a decision on a section 27 application. However, treatment consented to by the patient may continue.

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 - Notice of Hearing Before Review Panel).

A hearing must be held and the decision made and communicated to the patient and their guardian (if applicable) within **7 days** of when the review panel chair receives the application challenging Form 11 - Certificate of Incompetence to Make Treatment Decisions (section 40(3) of the Act, and Form 14 - Decision of Review Panel Regarding Mental Incompetence to Make Treatment Decisions).

There is a presumption at common law that adults are competent to make treatment decisions. If the physician's opinion is that the person does not have competence to make treatment decisions and the formal patient disagrees with this opinion, the onus is on the board of the facility in which the formal patient is detained to prove that the physician's opinion regarding mental competence to make treatment decisions is correct (section 42(b) of the Act).

If the review panel refuses to cancel the physician's certificate of incompetence (Form 11 - Certificate of Incompetence to Make Treatment Decisions), the formal patient has a right of appeal to the Court of King's Bench (section 43(1) of the Act). The application for an appeal must be made within 30 days of the decision.

6.7 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) of the Act requires a second opinion when the SDM is the patient's agent or nearest relative and the formal patient objects to the treatment. This step does not apply when the SDM is the patient's guardian or the Public Guardian.

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 formal patient states that they do 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.

6.8 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 - Application for Review Panel Hearing for a treatment order in **three** circumstances:

- when the physician is unable to treat a competent formal patient because the patient 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 SDM refuses consent to treatment on behalf of the formal patient who is a minor or is not mentally competent 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 their own treatment decisions in cases where the SDM is an agent or nearest relative and the patient has objected to the treatment.

If a competent formal patient or a 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(1) 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, the patient's agent, or guardian, one person designated by the patient, and, unless the patient objects, the patient's nearest relative (section 40(2) of the Act, and Form 13 - Notice of Hearing Before Review Panel).

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 or guardian (if applicable) (section 40(3) of the Act).

6.9 Best Interests Considerations in Treatment Orders

At the review panel hearing, the physician provides evidence and reasons why they are 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 with regard to the following considerations
    - 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,
    - the treatment is the least restrictive and least intrusive treatment that meets the above requirements.

"Note: this is the only type of review panel hearing where a patient's best interests may be considered by the panel in making their decision"

6.10 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) of the Act).

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 - Decision of Review Panel Regarding Treatment with the date and notice that the decision can be appealed to the Court of King's Bench within **30 days** after receipt of the decision.

Court of King's Bench Appeal

Appeals can be made in two circumstances.

- The patient has the right of appeal to the Court of King's Bench within **30 days** after receipt of the decision (section 43(1) of the Act). This would normally happen if a review panel makes an order directing that treatment be administered.

- Similarly, if a 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 King's Bench.

Provision for treatment while the patient is appealing a treatment order issued by a review panel to the Court of King'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/continue 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 King's Bench, no further appeals are possible.

6.11 Psychosurgery

Psychosurgery can never be performed on a formal patient unless the patient consents, and the review panel orders that the surgery may be performed (section 29(5) of the Act).

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 those conditions are clearly demonstrable (section 1(1)(m) of the Act). Electroconvulsive therapy (ECT) is not considered psychosurgery.

6.12 Questions about Consent, Competency and Treatment Decisions in Practice

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 SDM?**

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 …"

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 - Certificate of Incompetence to Make Treatment Decisions. Section 27(3) of the Act 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 - Certificate of Incompetence to Make Treatment Decisions to be filled out even when a formal patient has a guardian.

Section 28 of the Act 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 - Certificate of Incompetence to Make Treatment Decisions is not challenged under section 27 of the Act, 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 SDMs.

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, a qualified health professional 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 of the Act despite a formal patient's or SDM'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 an SDM when is a second physician's opinion required?**

Section 28(5) of the Act 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 of a formal minor patient sign them 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 King's Bench or they expire (section 7(1) of the Act).

The guardian should be encouraged to discuss with the physician their concerns and reasons for wanting discharge of the minor who is a formal patient. If there is no satisfactory resolution, they can make an application to the review panel to cancel certificates (assuming an application to a review panel has not already been made) or contact legal counsel or the Patient Advocate.

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

Section 28 of the Act deals with treatment decisions made on behalf of formal patients who are under the age of 18 and sets out a list of SDMs. That list should be consulted in order to determine the appropriate SDM.

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.

In practice, the majority of minors coming to hospital for psychiatric care are brought in by guardians who make treatment decisions on the minor's behalf even if the patient is voluntary and is in agreement with the admission and treatment.

7. Can a Substitute Decision Maker (SDM) 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 an SDM, section 28 of the Act sets out an order of precedence for selecting the SDM and directs that the person be apparently mentally competent, available, and willing to make the decision, etc.

If an incompetent formal patient's nearest relative (e.g., the patient's spouse) meets the criteria for an 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(1)(i)(i)(B) 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).

8. 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 agent or nearest relative when making treatment decisions on the patient's behalf?

"Expressed wishes" are not addressed in the Act; in Alberta, the agent or nearest relative must make decisions in the formal patient's (or person subject to a CTO) best interests and is not bound by the Act to 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.

9. 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 to make treatment decisions 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), guardian (as per Court Order granted under the former *Dependent Adults Act* or under the AGTA), or nearest relative.

- If the formal patient does not have a guardian or agent, or the agent or guardian is not available or willing to make the decision 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 looked to with respect to mental health treatment for adults who lack capacity, who are formal patients or who are subject to a CTO.

If a treatment decision relating to the patient's physical health is needed for an adult who lacks capacity to make treatment decisions and is a formal patient, look to the AGTA and the *Personal Directives Act* as to whom can consent to such treatment.

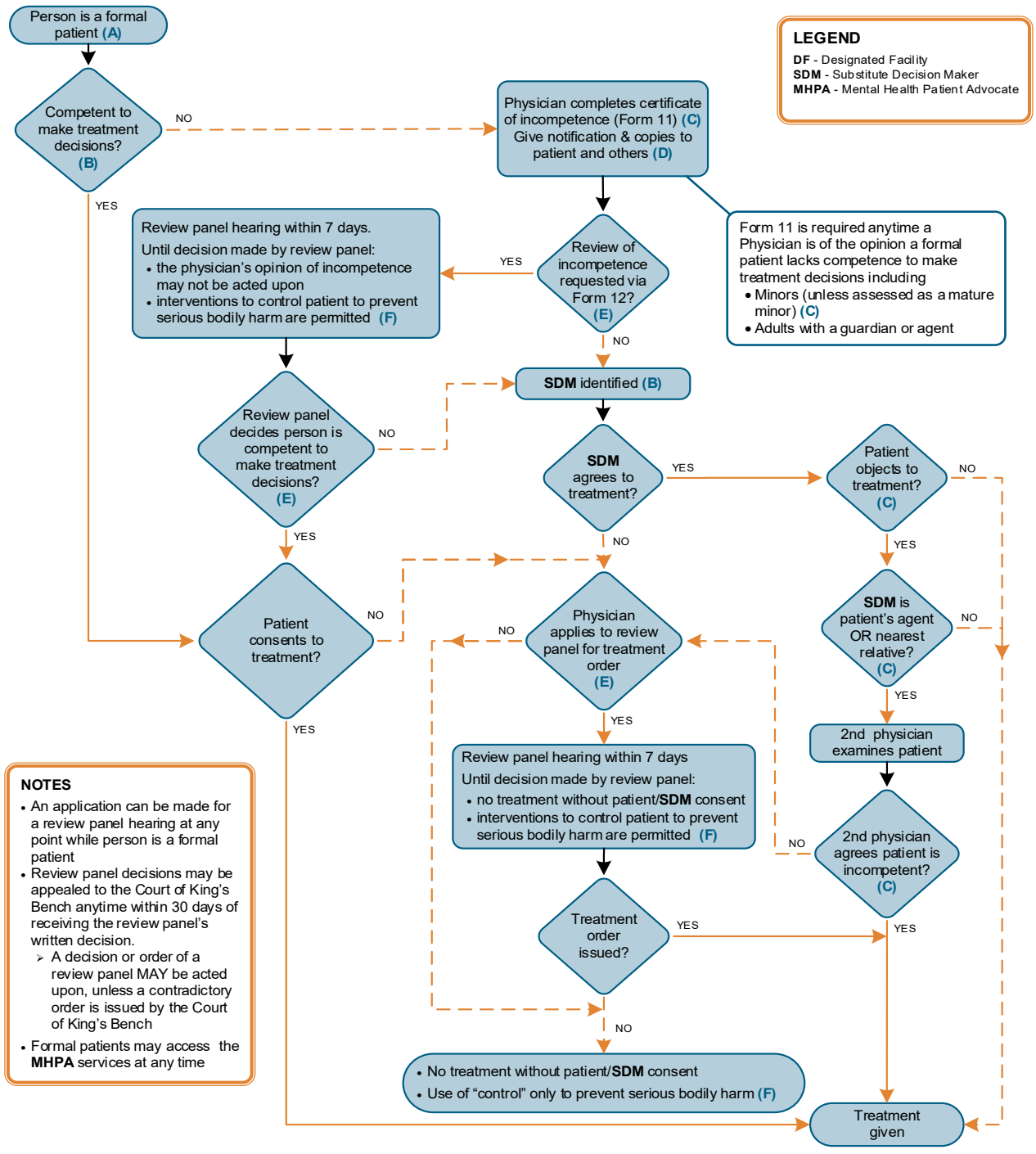
6.13 Flowchart: Competency & Consent – Formal Patient

Alberta Health Services

Competency & Consent - Formal Patient Flowchart

Mental Health Act (MHA) of Alberta

See Key Points for Reference Details A-F (over)



October 2022

Competency & Consent - Formal Patient Key Points

Mental Health Act (MHA) of Alberta

Definition of Mental Disorder (MHA s.1(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, but does not include a disorder in which the resulting impairment is persistent and is caused solely by an acquired or congenital irreversible brain injury.

A. Formal Patient (MHA s.1(e), s.2)

A patient detained in a designated facility pursuant to 2 admission or 2 renewal certificates. In both cases the following criteria must be met in the opinion of 2 QHPs:

1) suffering from a mental disorder
2) has the potential to benefit from treatment for the mental disorder
3) is within a reasonable time likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder
4) unsuitable for admission to a facility other than as a formal patient

B. Mental Competency (see MHA s.26-28)

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

When a physician determines a formal patient is incompetent to make treatment decisions, these decisions may be made by the:

a. agent of the formal patient (under an enacted personal directive)
b. guardian of the formal patient
c. nearest relative as defined in section 1(i), or
d. Public Guardian (last resort)

The nearest relative option is not utilized when an agent or guardian is in place. The SDM shall make the treatment decisions in the best interest of the formal patient.

C. Incompetence to Make Treatment Decisions (MHA s.27, s. 28)

- When a physician is of the opinion that a formal patient is not mentally competent to make treatment decisions, the physician shall submit a Form 11.
- Reasons for the opinion that the formal patient is not mentally competent must be included.
- When the SDM
  - is a **guardian**, any objection from the patient does not lead to any further requirements; treatment may proceed on the guardian's consent.
  - is an **agent or nearest relative**, and the patient objects to treatment, the MHA requires a second physician examination and opinion on the patient's competence, before treatment can proceed.
- When a second physician opinion is required, they would complete a separate Form 11.
- A **mature minor** is a person < 18 years old, who has been assessed and determined as having the intelligence and maturity to appreciate the nature, risks, benefits, consequences, and alternatives of the proposed treatment/procedure(s), including the ethical, emotional, and physical aspects.

D. Notifying Patients & Others (MHA s.27(3))

Who to notify:

- Formal patient
- Agent (if any)
- Guardian (if any)
- Nearest relative (unless patient objects on reasonable grounds)

What to include in the notification:

- A copy of the Certificate of Incompetence to Make treatment Decisions (Form 11)
- Written notice that the patient is entitled to have the physician's opinion of incompetence reviewed by a review panel
- A review panel hearing can be requested by sending a Application for Review Panel Hearing (Form 12)

E. Review Panels (MHA s.34-43, s. 14(1)(b)(x))

- Composed of a chair or vice-chair (lawyers), a psychiatrist and a member of the public
- The formal patient, or anyone on their behalf, may apply for a hearing via Form 12 to:
  - cancel admission/renewal certificates
  - request a CTO
  - overturn a physician's certificate of incompetence to make treatment decisions
- The formal patient has the right to legal representation at all review panel hearings.
- Prior to a hearing, formal patient is entitled to free & timely access to patient records relevant to review panel.
- A board or attending physician may apply to review panel for a treatment order.
- If an application is made to a review panel to review a physician's opinion that a formal patient is not mentally competent to make treatment decisions, neither a physician nor the board shall act on the opinion pending the outcome of the application.
- Any decision or order of the review panel may be appealed to the Court of King's Bench by the "applicant" of formal patient.
- A decision or order of a review panel MAY be acted upon, unless a contradictory order is issued by the Court of King's Bench.

F. Control (MHA s.30)

The MHA authorizes minimal use of reasonable force, by mechanical means or medication – without patient consent – as necessary to prevent serious bodily harm to the person or another. Means used must have regard for the physical and mental condition of the person.

Additional Information

- MHPA services are available at any time for all formal patients.
- In addition to the prescribed MHA forms referenced, all QHPs and any other staff assisting, are expected to follow professional standards and organizational guidelines for documentation

# Form Name	Completed by
11 Certificate of Incompetence to Make Treatment Decisions	Physician
12 Application for Review Panel Hearing	Patient (for review of incompetence opinion) Physician or Board (for Treatment Order request)

All Mental Health Act forms can be found on the website: https://www.albertahealthservices.ca/info/Page1256.aspx

For additional information on the Mental Health Act please visit https://www.albertahealthservices.ca/info/mha.aspx
For any enquiries about these materials please email: MHAandCTO.Enquiries@ahs.ca

October 2022

CHAPTER 7: Community Treatment Orders (CTO)

This chapter will cover

- why community treatment orders (CTOs) were created,
- what conditions/criteria must be met before a CTO is issued,
- how consent is handled,
- what is the exception to the need for consent, and how treatment and care plans are developed,
- what information is contained on the CTO,
- how the person who is subject to the CTO 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 CTOs in practice, and
- a review of the Flowchart and Key Points for Community Treatment Orders (CTO).

Background

Community treatment orders (CTOs) are largely dealt with in section 9.1 of the 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),
- 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 qualified health professional and the person responsible for supervising the CTO (section 8 of the CTO Regulation), and
- review by review panel on renewal of CTOs (section 9 of the CTO Regulation).

7.1 Introduction to Community Treatment Orders

Community treatment orders were implemented in Alberta 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 who are inpatients (whether formal or voluntary) 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 their behalf under section 28 of the Act, must give consent for a CTO 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 qualified health professional may determine a person meets the criteria for issuance 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 72 hours of the issuance of the CTO.

Section 9.1 of the Act identifies the criteria that must be met when two qualified health professionals, one of whom must be a psychiatrist, issue a CTO (Form 19 - Issuance of Community Treatment Order).

To be placed on a CTO the qualified health professionals must each believe that the person is:

1. Suffering from mental disorder,

2. Has one or more of the following apply:

(i) within the immediately preceding 3-year period the person has on 2 or more occasions, or for a total of at least 30 days,

(A) been a formal patient in a facility,

(B) been in an approved hospital or been lawfully detained in a custodial institution where there is evidence satisfactory to the 2 qualified health professionals that, while there, the person would have met the criteria set out in section 2(a) and (c) 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);

(ii) the person has within the immediately preceding 3-year period been subject to a community treatment order,

(iii) in the opinion of the 2 qualified health professionals, 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 others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder, if the person does not receive continuing treatment or care while living in the community,

(iv) a review panel has ordered a board to issue the community treatment order under section 41,

3. The **two** qualified health professionals after separate examinations within the preceding **72 hours** must both be of the opinion that the person is within a reasonable time likely to cause harm to others, or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or relating to the mental disorder, if they do not receive continuing treatment or care while living in the community (section 9.1(1)(c) of the Act).

4. The treatment or care the person requires must exist in the community, be available to the person and will be provided to the person (section 9.1(1)(d) of the Act).

5. The person must be able to comply with the treatment or care requirements in the CTO (section 9.1(1)(e) of the Act).

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

Review Panel Order

A review panel may order a board to issue a CTO in respect of a formal patient (section 9.1(1)(b)(iv) and section 41 of the Act). The CTO must be issued in a reasonable amount of time in accordance with the criteria in section 9.1 of the Act (section 2.1 of the CTO Regulation). The formal patient's admission or renewal certificates remain in effect until the CTO has been issued, or they have been cancelled by a physician, or expire, whichever happens first.

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 or renewing CTOs and for examinations related to apprehension orders.

7.3 Competency, Consent to a CTO and Consent to Treatment

Overview

This section will cover

- the person's competence to consent to treatment,
- Selection of a substitute decision-maker (SDM), if necessary,
- Exceptions to consent — Issuing a CTO without consent,
- Consent to treatment,
- consent to a CTO is separate from consent to treatment,
- signed consent for the issuing or renewal of a CTO, unless relying on an exception.

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 they are 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 they are not competent, this fact, as well as any reasoning for the conclusion regarding capacity, must be documented in the health record.

Selection of a substitute decision-maker (SDM)

If the person who will be subject to the CTO is not competent to consent to the issuance or renewal of a CTO

- a SDM's consent must be provided by a person who is competent to make decisions on the person's behalf; selection of an SDM must be made in accordance with sections 28(1) and 28(2) of the Act, and
- a SDM can consent to a CTO on the person's behalf (in Part V, Form 19 - Issuance of Community Treatment Order or Form 20 - Renewal of Community Treatment Order), 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 their SDM if applicable, refuses to consent to the issuing or renewal of the CTO, the issuing qualified health professionals 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 negative effects to the person, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder, or harm to others, and a CTO is reasonable in the circumstances and is less restrictive than detaining the person as a formal patient (section 9.1(1)(f)(ii)).

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 - Issuance of Community Treatment Order or Form 20 - Renewal of Community Treatment Order. There are **three** options identified, and **one** of them must be completed:

- consent by the 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 qualified health professionals must sign Part V.

7.4 The Process of Treatment and Care Planning

Having established that the person meets the criteria for a CTO, the qualified health professional 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 CTO and is included in Form 19 - Issuance of Community Treatment Order (Part III). It may state that the person who is subject to the CTO must take medications listed in the CTO (which may be adjusted based on clinical need) and attend appointments, accept telephone, or email contact or home visits, or receive treatment from listed providers or their designate. Thus, the development of the treatment and care plan should be done collaboratively, and, at the very least, include

- the issuing qualified health professional,
- the supervising qualified health professional (if this is not the issuing qualified health professional),
- the remaining 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 qualified health professional (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 they should always be involved in the development of the CTO even if they are not competent to consent to the issuance / renewal of the CTO.

The qualified health professional 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 their willingness to participate in and follow the requirements of a CTO. The qualified health professional should also review the person’s rights relative to the CTO. See section 7.7 below on Rights.

7.5 Contents of the CTO

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

- identify and be signed by the issuing qualified health professionals,
- note the dates and times when the examinations occurred,
- explain the qualified health professionals' 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., section 4 of the CTO Regulation requires the signature of the person authorizing services to be provided by regional health authority).

Noting that Forms 19, 20 and 21 include the written statement, which is part of the form to facilitate compliance with section 14(1.1) of the Act.

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 qualified health professionals** (one of whom must be a psychiatrist) 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 apply for a hearing to request that their CTO be cancelled. A person subject to a CTO may apply to a review panel to cancel the CTO, see Chapter 5).

7.6 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, and contain all necessary signatures and dates.

- The names of the person subject to the CTO, qualified health professionals, and treatment and care providers must be legible.
- 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 CTO.

    Service providers may consider having their manager or supervisor sign the treatment and care portion of the CTO in case the specific service providers change due to unavailability for any reason.

Signature to be provided by regional health authority representative

If any services are to be provided by a regional health authority (i.e., 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

The issuing qualified health professional must provide a copy of each CTO and any associated completed forms to the regional health authority (section 7 of the CTO Regulation). This is in addition to providing copies to the person and their SDM (if applicable) and the nearest relative unless the person objects on reasonable grounds as outlined in 7.7 Rights and Notification below.

The regional health authority must then promptly provide copies to:

- the person who is responsible for supervising the community treatment order, if that person is not the issuing qualified health professional, and
- the person who is responsible for providing the written statement referred to in section 8, if that person is not the regional health authority.

the nearest relative of a person who is subject to a community treatment order is prescribed to be a person to whom a written statement and a copy of an issued, amended, or renewed community treatment order must be given under section 14(1.1) of the Act, unless the person subject to the order objects on reasonable grounds.

In Practice: the issuing qualified health professional, may not be the qualified health professional who supervises the CTO in the community. Only a psychiatrist can issue an expiry/cancellation form. Both may be supported by other staff so that this responsibility will be met. Exact processes may vary by RHA.

7.7 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 qualified health professional to prepare and provide a copy of the issued, amended, or renewed CTO (Form 19 - Issuance of Community Treatment Order or Form 20 - Renewal of Community Treatment Order or Form 21 - Amendments to Community Treatment Order) with the following information (section 14(1.1)(a) of the Act):

- 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.

"This information is set out in the first section of Forms 19, 20 and 21. A complete and legible form meets these requirements for written notice."

This notice must be given by the issuing qualified health professional to:

- the person subject to the CTO,
- the person's SDM, if any,
- 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
- the nearest relative, unless the person subject to the community treatment order objects on reasonable grounds.

Verbal explanation

It is pertinent to present information on the contents of the CTO to the person subject to a CTO and/or their SDM. Information, including the function of the review panel and the Patient Advocate, should also be communicated verbally, and in simple language.

Interpreter

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

Mental Health Patient Advocate (Patient Advocate)

The role of the Patient Advocate extends to a person subject to a CTO (section 45 of the Act). The person should be advised that they may contact the Patient Advocate for rights information, expression of concerns, and complaints about their rights, care, and treatment. The Patient Advocate is authorized to investigate and resolve complaints from or relating to persons who are subject to CTOs (section 45(1.1)(e) of the Act). The Patient Advocate may contact and advise a person who is subject to a CTO at any time, regardless of whether a complaint has been received from or relating to a person who is subject to a CTO (section 45(1.2) of the Act). The Patient Advocate must notify the qualified health professional who last issued, renewed, or amended a CTO or issued an apprehension order where a patient complaint relates to that issuing qualified health professional (section 5(4) of the Mental Health Patient Advocate Regulation).

Written material

Information about CTOs, review panels, Legal Aid and the Patient Advocate is available to be given the person subject to the CTO and their SDM.

The following fact sheets are available for downloading:

- *Mental Health Act* Information about mental health review panels https://open.alberta.ca/publications/mental-health-act-information-about-mental-health-review-panels
- *Mental Health Act* Information for persons subject to a community treatment order https://open.alberta.ca/publications/mental-health-act-information-for-persons-under-community-treatment-order

The Mental Health Patient Advocate provides brochures titled Your Rights Under the Mental Health Act: Community Treatment Orders

Legal Aid Alberta - https://www.legalaid.ab.ca/services/mental-health-law/

Mental Health Act forms, including Form 12 - Application for Review Panel Hearing are available on the Alberta Health Services website: https://www.albertahealthservices.ca/info/Page1256.aspx

7.8 Application to a Review Panel to Cancel a CTO

An individual subject to a CTO can request cancellation of their CTO by completing Form 12 - Application for Review Panel Hearing - available online or from their supervising qualified health professional, 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).

It is important that the Form 12 is sent to the correct review panel chair. However, if a review panel chair receives an application for review of a CTO outside the chair's geographic area, the application will immediately be forwarded by the chair to the appropriate review panel chair (section 9(2) of the CTO Regulation).

Review panel hearings are held in the area in which the person subject to the CTO resides. 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 a 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 for its issuance are no longer 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 King's Bench (section 41(3) of the Act). The appeal must be initiated within 30 days of receiving the decision. (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 **second** 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 person subject to the CTO and their 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).

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

7.9 CTO Renewal, Amendment, Cancellation or Expiry

Renewal

CTOs expire 6 months after the day they are issued unless they are renewed (Form 20 - Renewal of Community Treatment Order) 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 and Form 22 – Community Treatment Order Cancellation or Expiry). There is no limit on the number of renewals allowed. The requirements of section 9.1 of the Act apply to the renewal except for the requirement that the separate examinations by qualified health professionals must occur within the immediately preceding 72 hours. In the case of a renewal, the separate examinations by qualified health professionals must occur within the immediately preceding 7 days (section 9.3(4) of the Act).

Amendments

The regulations set out a procedure for amending conditions of the CTO (section 9.4 of the Act). Amendments may include changing the treatment and care plan (such as the service provider) or the supervising qualified health professional. The person subject to the CTO may request amendments and, generally speaking, conditions can be amended by an issuing qualified health professional (in communication with the person subject to the CTO) at any time. However, the onus remains on the issuing qualified

health professional 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 amended CTO. An issuing qualified health professional amends a CTO using Form 21 - Community Treatment Orders Amendments to Community Treatment Order.

Form 19 - Issuance of Community Treatment Order (Part III) and Form 20 - Renewal of Community Treatment Order (Part III) state 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. If the Form 19 or 20 is written in this way, an amendment (Form 21 - Community Treatment Orders Amendments to Community Treatment Order) would only 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 - Community Treatment Order Cancellation or Expiry, if criteria set out in section 9.1(1)(b) to (d) cease to apply.

In a situation where a person subject to a CTO or, if applicable, their SDM, no longer agrees to the CTO, they may discuss this with the qualified health professional who is supervising the CTO. A qualified health professional may, as appropriate, amend the CTO or if the person is refusing to comply with the terms of their CTO despite best efforts, issue an apprehension for the person. The person also has the option to apply to the review panel for cancellation of the CTO, and the review panel will either cancel or refuse to cancel the CTO.

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 physician or nurse practitioner who treats the person in their ordinary day-to-day health care needs, if known (section 14(5) of the Act).

Notification is given and Form 22 - Community Treatment Order Cancellation or Expiry is completed and distributed by a qualified health professional upon cancellation or expiry of a CTO (section 14(5) of the Act). Section 8(2) of the CTO Regulation provides

that the person responsible for giving notice of expiry or cancellation is the person responsible for the supervision of the CTO. Section 3 of the CTO Regulation stipulates that a CTO may be supervised only by a qualified health professional.

7.10 Failure to Comply

Reporting requirement

Individuals identified on the CTO as providing 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 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 25 - Community Treatment Order Non-compliance Report.

Upon receiving notice of failure to comply with treatment or care (Form 25 - Community Treatment Order Non-compliance Report), the regional health authority is obligated to provide copies of the form to the qualified health professional 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 (section 9.6 of the Act, Form 23 - Community Treatment Order Apprehension Order). The Act requires that, prior to issuing the CTO apprehension order, a qualified health professional 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 them to comply with the treatment or care in the CTO and be advised of the consequences of non-compliance which include

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

Only a qualified health professional may complete the CTO apprehension order.

> **A person cannot be forced to accept treatment or care or comply with the treatment or care outlined in a CTO**. If they are not complying, the treatment team will follow the steps outlined above – to support and inform the person, potentially amend the CTO, and advise the person of the consequences of continued non-compliance. Consequences include

having the person taken to a designated facility for examination with a possible outcome of admission as a formal patient.

7.11 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 - Community Treatment Order Apprehension Order)

- A CTO apprehension order is completed and signed by a qualified health professional 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.
- The CTO apprehension order gives a peace officer authority to apprehend the person, which includes the authority to enter premises, use of physical restraint, and take the person 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 qualified health professional must indicate on the CTO apprehension order 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 - Warrant)

- A judge's warrant is issued when someone brings information under oath before a judge about a person subject to a CTO regarding reasonable and probable grounds to believe the named person is not complying with their CTO (Form 7 - Information).
- If the judge believes that the person is subject to a CTO and is not complying with their CTO, and an examination cannot be arranged in another way, the judge may issue a warrant (Form 8 - Warrant).
- The warrant gives peace officers the authority to apprehend and convey the named individual to a designated 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 - Extension of Warrant is used to extend the warrant.

3. By **acting pursuant to section 12(1) of the Act under peace officer discretion** (Form 10 - Statement of Peace Officer on Apprehension)

In order to apprehend and convey the person to a designated facility for examination pursuant to section 12(1) of the Act, the peace officer must have reasonable and probable grounds to believe

- the person is suffering from a mental disorder,
- the person 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 (i.e., judge's warrant) would be dangerous.

- The apprehension order gives peace officers sufficient authority to care for, observe, assess, detain, and control the person. (section 12(2) of the Act).

Examination at a designated facility

As soon as practicable and, at the most, within **72 hours** of being conveyed to a designated facility under Form 23 - Community Treatment Order Apprehension Order, Form 8 - Warrant or Form 10 - Statement of Peace Officer on Apprehension, the person subject to the CTO must be examined by **two** qualified health professionals, **one** of whom must be a psychiatrist (Form 24 - Community Treatment Order Examination on Apprehension). Under section 9.6(4) of the Act, the **two** qualified health professionals 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.

7.12 Questions about Community Treatment Orders in Practice

1. **When a CTO is issued in respect of a formal patient, are their admission/renewal certificates automatically cancelled or is a Form 2.1 - Cancellation of Admission Certificate or Renewal Certificate required 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". No Form 2.1 - Cancellation of Admission Certificate or Renewal Certificate is required.

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

A qualified health professional may issue, renew, or amend a CTO. Issuances and renewals of CTOs require two qualifying health professionals, and one must be a psychiatrist. Only a psychiatrist may cancel a CTO.

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

It is up to the issuing qualified health professional to determine what provisions they feel can validly be part of a CTO. A CTO treatment and care plan will be specific to the person subject to the CTO, their needs, and goals. This CTO treatment and care plan 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, or provisions that, if not met, would not normally necessitate apprehension and conveyance to a facility by a peace officer.

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

The Act does not speak to documentation on the health record, 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 providers' 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 qualified health professional). 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).

The process described may result in multiple copies of the pages requiring signatures. This is preferable to having all the necessary signatures on one document that becomes very difficult to read due to repeated faxing.

6. At what point does the CTO come into effect?

The CTO is considered *issued* when **two** qualified health professionals (one of whom is a psychiatrist) have signed the CTO on Forms 19 or 20 – Parts I and II (Form 19 - Issuance of Community Treatment Order and Form 20 - Renewal of Community Treatment Order).

For a CTO to be *valid*, the **two** qualified health professionals must have each examined the person (separately) within 72 hours of signing / issuing, the CTO, or within 7 days if it is a renewal of the CTO (section 9.3(4) of the Act).

- 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, and consent has been obtained from the person subject to the CTO or their SDM (or signatures have been obtained from both qualified health professionals if the CTO is being issued without consent).
- A supervising qualified health professional must be identified (if this is not the issuing qualified health professional).
- 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 qualified health professional 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) can be provided, that all of the providers have been consulted and agree to and have signed the order. When all of these components are in place, it may be necessary for the qualified health professional(s) to re-examine the person to ensure the criteria are met within the required timelines (72 hours for the issuance of the CTO, and 7 days for renewals).

Parts I through V of the form must be completed legibly, with all necessary signatures for the CTO to be issued or “in effect”. It is recommended the Written Statement of the form also be done when the form is issued in order for the entire form to be complete and to adhere to the requirement for a written statement in section 14(1.1) of the Act.

7. How long is a CTO valid?

A CTO “expires **6 months** after the day it was issued” unless it is renewed or cancelled (section 9.2 of the Act). The key terms here are “months” and “after”. Computation of time is clarified in section 22(8) of Alberta’s *Interpretation Act*. 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, 2020 would expire February 28, 2021. Note that 6 months plus a day would be February 31st; but February 2021 has only 28 days. Because section 22(8) of the *Interpretation*

Act can be confusing, caution should be taken (and legal advice sought if necessary) when calculating the 6-month period.

The Act 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.

8. The Act frequently refers to the "issuing qualified health professional" in reference to CTOs. Is this the qualified health professional who first issued the original CTO?

Not necessarily. The regulations define the "issuing qualified health professional" as the qualified health professional who completed Part I of the most recent Form 19 – Issuance of Community Treatment Order, or Form 20 – Renewal of Community Treatment Order, or who amended the CTO (Form 21 – Community Treatment Order Amendments to Community Treatment Order).

9. Who can supervise a CTO?

The CTO must be supervised by a qualified health professional (section 3 of the CTO Regulation). A CTO may often be initiated by a psychiatrist while the patient is in a facility as a formal patient. If the psychiatrist is not able to continue as the supervising qualified health professional, another community psychiatrist, physician, or qualified health professional (e.g., nurse practitioner) 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.

10. Can a peace officer enter a person's premises in order to apprehend that person when executing a CTO apprehension order (Form 23 - Community Treatment Order Apprehension Order)?

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. Specifically, Form 23 states that it authorizes peace officers to "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". This same authority does not exist for sections 10 or 12 of the Act.

11. Having conveyed a person identified in a CTO apprehension order or a judge's warrant to a designated facility for examination, is a peace officer also

required to complete a Form 10 - Statement of Peace Officer on Apprehension?

No; duplicate forms are not required. Each one of these three processes, whether Form 8 - Warrant (section 10), **or** Form 23 - Community Treatment Order Apprehension Order (section 9.6), **or** Form 10 - Statement of Peace Officer on Apprehension (section 12), 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.

12. If an amendment is made to the CTO, does the whole order have to be re-written on Form 21 - Community Treatment Orders Amendments to Community Treatment Order, 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 - Community Treatment Orders Amendments to Community Treatment Order. 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 - Issuance of Community Treatment Order) or the renewed CTO (Form 20 - Renewal of Community Treatment Order) unless a particular requirement is expressly changed on Form 21.

13. 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.

Mental Health Act forms are legal documents, so it is important that they are filled out completely and accurately. If information is missing on a form, or added after the form is signed, it is possible that the form will not be valid. Healthcare providers may address specific questions to their organization's internal legal services.

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

Section 28 of the Act sets out a list of SDMs 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. For more information specific to mature minors see Chapter 6.

15. Can outside agencies confirm with a regional health authority (i.e., Alberta Health Services) 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 the HIA the health authority can only disclose this type of patient information if

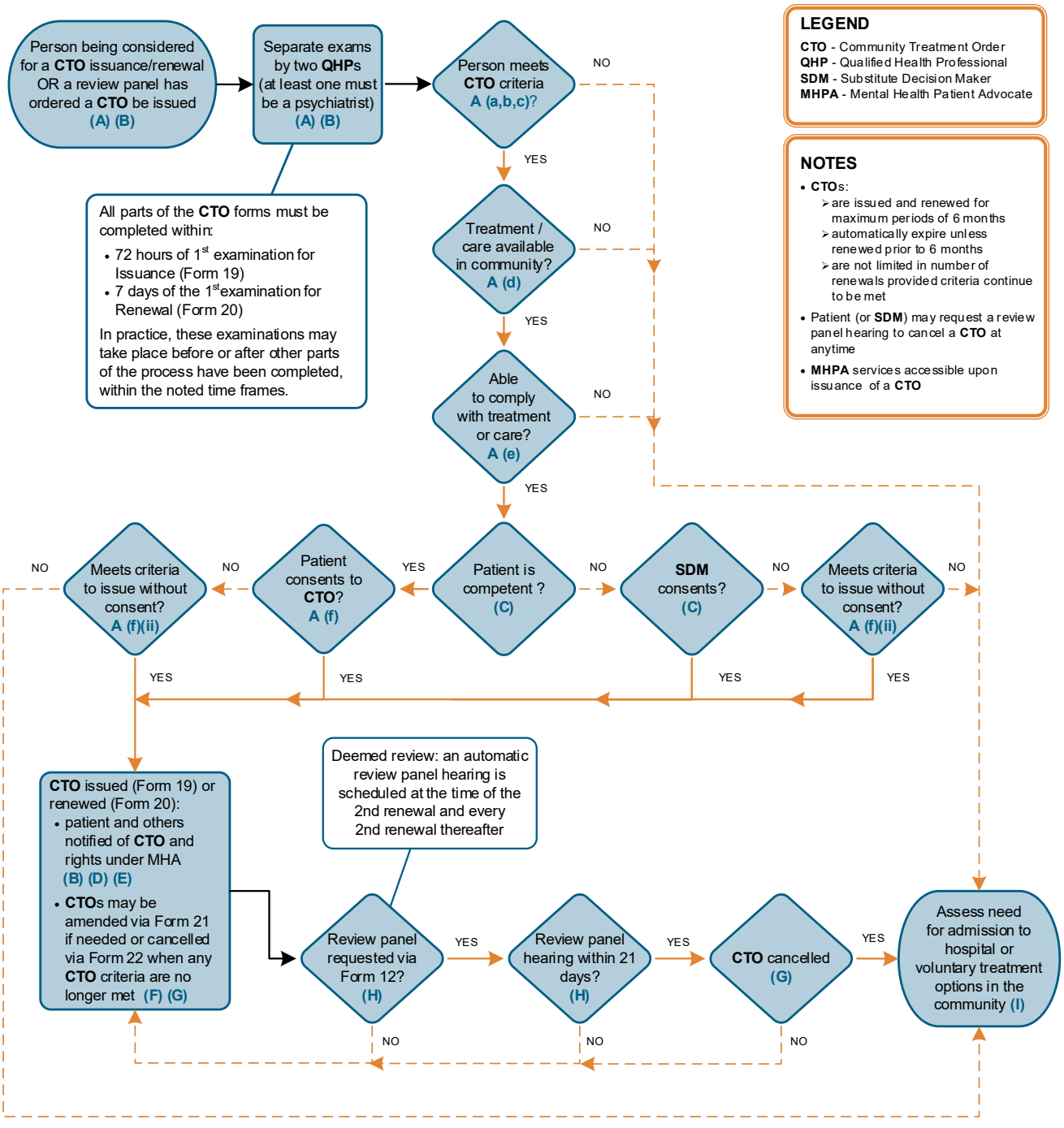
- the patient has consented in accordance with section 34 of the HIA, or
- the disclosure falls within an exception listed in section 35 of the HIA.

Whether or not the disclosure can occur depends on *to whom the health authority is disclosing*, and *for what purpose*. It is recommended that the Information and Privacy department for AHS or Covenant Health be consulted with respect to disclosure in particular circumstances, since the answer will depend on the facts of each situation.

7.13 Flowchart: Community Treatment Orders

See Key Points for Reference Details A-I (over)

In Practice: Forms 19 and 20 are 6 part forms required for the issuance and renewal of a **CTO** respectively. The issuing **QHP** may determine a person meets the criteria for a **CTO**, but undertake treatment planning and obtain signatures under parts III and IV before the required examinations and completion of parts I and II of Form 19/20. Parts V and the Written Statement are usually the final parts to be completed.



Alberta Health Services

Community Treatment Order Key Points

Mental Health Act (MHA) of Alberta

Definition of Mental Disorder (MHA s.1(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, but does not include a disorder in which the resulting impairment is persistent and is caused solely by an acquired or congenital irreversible brain injury.

A. Criteria for CTO (MHA s.9.1(1))

Two QHPs - one MUST be a psychiatrist - may, issue a CTO with respect to a person if they meet **a) through f)**:

a. person is suffering from a mental disorder, **and**

b. **one or more** of the following apply:
   i. within the immediate preceding 3-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 QHP that, while there, the person would have met the criteria (for a formal patient) at that time or those times, **or**
      C. both A. and B. above
   ii. the person has within the immediately preceding 3-year period been subject to a CTO
   iii. in the opinion of the two QHPs, 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 others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder, if the person does not receive continuing treatment or care while living in the community, or
   iv. a review panel has ordered a board to issue the CTO under MHA s.41,

c. Two QHPs, after separate examinations of the person within the immediately preceding 72 hours, are both of the opinion that the person is within a reasonable time, likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder, if the person does not receive continuing treatment or care while living in the community, **and**

d. 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 QHP, the person is able to comply with the treatment or care requirements set out in the CTO, **and**

f. either,
   i. consent to the issuing of the CTO has been obtained,
      A. from the person, if they are competent, **or**
      B. in accordance with section 28(1), if they are not competent
   or
   ii. consent to the issuing of the CTO has NOT been obtained, but in the opinion of the issuing QHPs,
      A. 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 negative effects to the person, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder, or of harm to others, **and**
      B. a CTO is reasonable and would be less restrictive than retaining the person as a formal patient.

B. Issuing/Renewing a CTO

(MHA s.9.1, s. 9.2, s. 9.3; CTO Reg. s. 1-2)

- Renewal criteria are the same as issuance criteria (see A) except the allowable time between the first examination and completion of all parts of the prescribed form is 7 days instead of 72 hours.
- "Issuing qualified health professional" means the QHP who last issued, renewed, or amended a CTO.
- Examinations for the purposes of issuance or renewal may be conducted remotely using any means considered appropriate by the examining QHP, including, but not limited to, video conference.
- A CTO is valid for 6 months and can be renewed anytime before its expiry.
- Formal patient admission or renewal certificates are automatically cancelled upon the issuance of a CTO.

C. Mental Competency (MHA s.26, s. 28)

Competency means that a 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.

When a physician determines a person subject to a CTO is incompetent to make treatment decisions, these decisions may be made by the:

a. agent of the person (under an enacted personal directive)
b. guardian of the person on a CTO
c. nearest relative as defined in section 1(i), or
d. Public Guardian (last resort)

The nearest relative option is not utilized when an agent or guardian is in place. The SDM shall make the treatment decisions in the best interest of the person.

D. Form Requirements (MHA s.9.1(2) CTO Reg. s.4)

Must be written on the correct and most current version of the form (Form 19 or 20)

- Identify and be signed by the issuing QHP, a second examining QHP, the supervising QHP (if different from issuing QHP) and all treatment providers ❖
- Contain the dates and location (city/town & facility) of the examinations, the rationale/ facts from which the examining QHPs formed their opinions and the treatment and care to be provided.

❖ if the treatment and care plan requires services provided by the regional health authority (i.e., AHS), a person authorized to approve the service must sign the CTO (e.g., Program Manager).

E. Notification of CTO Issuance, Amendment and Renewal

(MHA s.14(1.1), s. 14(2), s. 14(4) CTO Reg. s.7, s.8)

Who to notify:

- Person subject to CTO
- SDM under MHA s. 28 (if any)(see C above)
- Issuing QHP
- Supervising QHP
- ALL treatment providers named in the CTO
- Nearest relative (unless patient objects on reasonable grounds)
- One person designated by person subject to CTO (if any)

What to include in the notification:

- Copies of issued, amended or renewed CTO
- Written statement (of Forms 19, 20 & 21) with the following requirements in simple language, using an interpreter if required ❖ :
  - ✓ reason & authority for issuance, amendment or renewal of CTO
  - ✓ function & contact information of the review panels
  - ✓ right of the person subject to the CTO to apply for a review panel hearing to cancel a CTO

❖ only for person subject to CTO or their SDM

F. Amendment Considerations (MHA s. 9.4)

- A CTO can be amended by a QHP.
- An amendment must be on Form 21 with copy of most recent CTO (Form 19 or 20) attached.
- If medication is stated by class (e.g., "antidepressant" in Part III of a Form 19 or 20), adjustments within that class of medication do not require an amendment.

G. Cancellation/Expiry (MHA s.9.2, s.9.5; CTO Reg. 8(2))

- A CTO can only be cancelled by a psychiatrist, review panel decision, or Court of King's Bench.
- If the supervising QHP is not a psychiatrist, consultation with a psychiatrist when CTO criteria no longer met is required to complete Form 22.
- Supervising QHP to issue notice of the expiry of a CTO on Form 22.
- All individuals notified of the issuance, amendment or renewal of a CTO (see **E**), as well as the physician or nurse practitioner who treats the person in their ordinary day-to-day health care needs (if known) requires notification of expiry or cancellation, along with any recommendations for treatment.

H. Review Panel (MHA s.34-43; CTO Reg. 9(1))

- The person subject to a CTO or anyone on their behalf, may apply for a review panel hearing via Form 12 to cancel a CTO.
- Review panel is composed of a chair or vice-chair (must be lawyers), a psychiatrist & a member of the public.
- Review panel to be held within 21 days of the chair receiving the application, and their decision to be issued within 48 hours of the hearing.
- The person subject to a CTO has the right to legal representation at all review panel hearings.
- Issuing QHP to send copy of renewal forms to review panel for deemed applications.
- Any decision or order of the review panel may be appealed to the Court of King's Bench.

I. Non CTO Clinical Considerations

- When a person does not meet the criteria for a CTO, the CTO has expired or has been cancelled, care providers should consider:
  - ➢ need for hospital admission either as a formal patient (see MHA s.2 for admission criteria) or as a voluntary patient.
  - ➢ any treatment recommendations the person may be willing to accept voluntarily.

Additional Information

- Informed consent to treatment is a separate process from consent to CTO.
- Treatment providers are responsible to obtain and appropriately document informed consent for the treatment they provide.
- In addition to the prescribed MHA forms referenced, all providers are expected to follow professional standards and organizational guidelines for documentation.

All Mental Health Act forms can be found on the website: https://www.albertahealthservices.ca/info/Page1256.aspx

For additional information on the Mental Health Act please visit https://www.albertahealthservices.ca/info/mha.aspx
For any enquiries about these materials please email: MHAandCTO.Enquiries@ahs.ca

CHAPTER 8: Confidentiality and Access to Information

This chapter will cover

- what is the purpose 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, and
- 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 HIA provisions also apply.

Section 17(1)(b) defines "diagnostic and treatment centre" or "centre" as "a place established by the Minister pursuant to section 49(1)(a) or (b) and includes a facility that is not an approved hospital under the *Hospitals Act* and a hospital under the jurisdiction of a provincial health board under the *Regional Health Authorities Act*".

Purpose

The Health Information Act (HIA) establishes rules to protect the privacy of an individual's health information. It also regulates how health information can be collected, used, and disclosed.

The HIA contains rules about the collection, use and disclosure of health information by "custodians." The legislation's purpose 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 HIA helps those working in healthcare understand the parameters for using and disclosing health information in practice.

The term "**custodian**" in the HIA, includes, among others, regional health authorities and designated facilities (see Appendix III).

> For example, currently there is only one regional health authority - Alberta Health Services (AHS). AHS is a custodian under the HIA. Covenant Health has been designated as a custodian under the HIA (section 2(1)(c) of the Health Information Regulation).

The Mental Health Patient Advocate and review panels appointed under the *Mental Health Act* are also designated as custodians (section 2(1) of the Health Information Regulation).

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., contractor, volunteer, or student), and
- health services 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 to any person or organization external to the custodian and

- includes sending health information from one custodian to another custodian or non-custodian, but
- does **not** include the sharing of information between a custodian and their affiliate(s).

Principles

Relevant principles underlying the legislation are referred to in the Health Information Act Guidelines and Practices Manual can be located at https://open.alberta.ca/publications/9780778582922. The principles include:

- custodians are the trusted "gatekeepers" of an individual's 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, and
- 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 if there are errors in it, 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 HIA.

8.2 The Right to Access Health Information

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

- the individual who is **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 these 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 AGTA 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,
- the nearest relative of a formal patient under the *Mental Health Act* to carry out obligations or exercise rights under the Act, or
- by any person with the individual's written authorization to act on their behalf, e.g., legal counsel.

8.3 The Right to Refuse Access to Health Information

The relationship between the *Mental Health Act* and the HIA is complex. For assistance with interpretation of this legislation, ideally, legal advice should be sought.

Section 11(1)(a) of the HIA 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 *may* 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. As an example, disclosure must be refused 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 (section 11(2) of the HIA).

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. Health information is to be shared internally on a 'need-to-know' basis (section 58 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 (section 27(1)(a) of the HIA).

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.

There are mandatory provisions for disclosure upon discharge in the Mental Health Act discussed below (Notification of Discharge). The discretionary provisions in section 35(1)(b) of the HIA allow for information to be sent to those persons who are responsible for providing continuing care and treatment.

Risk of Harm

A provision in the HIA permits a custodian to disclose health information without consent to any person if the custodian believes on reasonable grounds that the disclosure will avert or minimize:

(i) a risk of harm to the health or safety of a minor, or
(ii) a significant risk of harm to the health or safety of any person (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 of the HIA).

    In this instance, if a healthcare provider employed by or contracted with AHS does not want to disclose to the police and wants to disclose to the Minister, the healthcare provider can contact AHS Legal for information about who in the Ministry to contact. Otherwise, the healthcare provider 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 (sections 11(b) and 12(b) of the *Fatality Inquiries Act*).

> 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 a pass/leave from hospital), 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

> *21(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

The *Emergency Health Services Act* provides for the disclosure of certain information by ambulance attendants to peace officers without the 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* 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, healthcare 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*, 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 HIA.

Mental Health Act

The notification provisions in section 17(9) and section 32 of the Act apply to all patients, including voluntary and formal patients.

a) Section 17(9)

- When a patient is discharged from a diagnostic and treatment centre for the purposes of transferring them 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.

b) Section 32

- 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 the patient's discharge if the patient does not object on reasonable grounds.
  - As an example, this could apply when a voluntary patient discharges themself 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).
- Section 32 of the Act requires notification of the family physician or nurse practitioner who treats the patient in their ordinary day-to-day health care needs, 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.

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.

8.7 Questions about Access, Use and Disclosure of Health Information in Practice

1. **What information is disclosed to the physician or nurse practitioner who treats the patient in their ordinary day-to-day health care needs 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 physician or nurse practitioner who treats the patient in their ordinary day-to-day health care needs, 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 their physician or nurse practitioner who treats the patient in their ordinary day-to-day health care needs though notifying the patient is not a requirement under the Act.

Health information **may** also be provided to a person who is responsible for providing continuing treatment and care to the individual (section 35(1)(b) of the HIA), such as a mental health clinic where the person received services prior to admission.

2. **What if a patient specifically instructs their qualified health practitioner not to send discharge notice and follow-up information to the family physician or nurse practitioner who treats the patient in their ordinary day-to-day health care needs?**

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 or nurse practitioner who treats the patient in their ordinary day-to-day health care needs, 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 their 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 HIA 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.

Note: A formal patient does not need to make a request for their medical records if they have made an application to the review panel (per section 14(6) of the MHA.

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 their chart, it is helpful if staff inform the attending physician of the patient's request so the physician and patient can discuss it.

Affiliates (e.g., employees) 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 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 patients who are minors, minors who are subject to CTOs, voluntary patients who are minors and mature minors) request access to their health record?

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

To determine whether a person under the age of 18 is a mature minor capable of understanding the nature and consequences of exercising their rights or powers under the HIA, the following factors are considered

- 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 the HIA is not a particularly onerous standard (OIPC Order F2005-017 and H2005-001).

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

If healthcare providers need guidance whether a mature minor under the Act can expressly preclude their guardian from obtaining the mature minor'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 HIA provides that so long as disclosure is not contrary to the patient's expressed wishes, the custodian *may* provide limited information to persons in a close personal relationship with the patient 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 they have such a relationship with the patient (section 35(1)(c) of the HIA).
- Section 14(1) of the *Mental Health Act* addresses disclosing information as well. For instance, notifications of a formal patient's certification and of the formal patient's rights are provided to the patient's nearest relative, unless the patient objects on reasonable grounds. Formal patients are also asked to designate a person they wish to receive the written statement and copies of the information required in sections 14(1)(b) and 14(1)(c) of the Act. 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 AGTA or guardians of patients who are minors.
- Note: similar provisions for disclosing information exist beyond section 14(1) across the Act (e.g., 18(1), 32(1)(b) and CTO Regulation section 7(3).
- Similarly, the team can engage in treatment-related communication with agents and SDMs 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 SDM 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 Alberta Health publication (2018), ***Health Information Act* - Guidelines and Practices Manual** ("HIA Guidelines and Practices Manual"), available at: https://open.alberta.ca/publications/9780778582922

CHAPTER 9: Mental Health Patient Advocate

This chapter will cover

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

Introduction

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

The Mental Health Patient Advocate is appointed by the Lieutenant Governor in Council (*Mental Health Act* RSA 2000, c M13 ("MHA"), s 45(1) and operates independently of the government. The Mental Health 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
c) is or has been subject to a community treatment order.

A complaint may be investigated by the Patient Advocate or an employee of the Patient Advocate. Employees may be appointed to assist the Advocate (section 46(1) of the Act). The Patient Advocate may in writing delegate to any person any power or duty under the Act or the Mental Health Patient Advocate Regulation, except for the power or duty to make a report (section 2 of the Mental Health Patient Advocate Regulation).

In this chapter, the term "patient" will have the same meaning as in the regulation.

9.1 Jurisdiction

The Patient 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 a community treatment order (CTO).

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

9.2 Investigations Based on Complaints

The Patient Advocate has jurisdiction to investigate complaints from or relating to

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

The Patient Advocate does **not** have the jurisdiction to investigate complaints regarding voluntary patients. Section 6(5) of the Mental Health Patient Advocate Regulation limits the Patient 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 Patient 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 for the patient during that hospitalization.

9.3 Investigations without a Complaint

Without receiving a complaint, section 4(1) of the Mental Health Patient Advocate Regulation enables the Patient Advocate to initiate and conduct an investigation into any matter under the Act relating to a patient with or without the patient's consent. Further, without receiving a complaint the Patient Advocate may initiate and conduct an investigation into

- 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 their rights, or 2) providing information as required by the Act to a patient and to guardians, nearest relative or designates of a patient, and

- any procedure of a regional health authority or issuing qualified health professional relating to the issuance, amendment, or renewal of a CTO.

9.4 Rights Advice

Section 45(1.1) of the Act requires the Patient Advocate to contact each formal patient who has requested contact as soon as practicable after receipt of the patient's admission certificates or renewal certificates. The Patient Advocate may provide to each formal patient, the patient's guardian, if any, one person designated by the patient and, unless the patient objects, the patient's nearest relative, information respecting:

- the authority for the patient's detention and the period of it,
- the function of review panels,
- the name and address of the chair of the review panel for the facility,
- the right to apply to a review panel for cancellation of the admission certificates or renewal certificates or for an order for the board to issue a community treatment order, and
- the right of a patient to free and timely access to their medical records relevant to a hearing before a review panel or the Court of King's Bench.

The Patient Advocate must ensure that all formal patients have been provided complete information by the board under section 14 of the Act.

As well, the Patient Advocate must review the summary of information provided by the board under section 14 of the Act with the formal patient.

The Patient Advocate may contact and advise a formal patient or a person who is subject to a CTO at any time, regardless of whether a complaint has been received from or relating to the formal patient or person who is subject to a CTO (section 45(1.2) of the Act).

After receiving a complaint or initiating an investigation without a complaint into any matter under the Act relating to a patient, section 6(2) of the Mental Health Patient Advocate Regulation requires that the Patient Advocate provide to the complainant or the patient to whom a matter under investigation relates, as far as is reasonable, information about:

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

9.5 Notification Requirements

Section 5(1) and section 5(5) of the Mental Health Patient Advocate Regulation provide that the Patient Advocate must issue a notice of investigation as follows:

- notify the board of the facility where the patient is or was detained that an investigation has been initiated and the nature of the matter or complaint under investigation,
- if a patient has been transferred, notify the board of both facilities,
- notify the patient in writing if the Patient Advocate is conducting an investigation without complaint under section 4(1) of the Mental Health Patient Advocate Regulation that an investigation has been initiated and the nature of the matter under investigation,
- 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(2) of the Mental Health Patient Advocate Regulation requires that the Patient Advocate notify the board of the facility of the Patient Advocate's intention to contact a patient of the facility.

Where the Patient Advocate investigates without complaint a procedure that relates to a facility, the Patient Advocate must notify the board of the facility (section 5(3) of the Mental Health Patient Advocate Regulation).

The Patient Advocate must notify the regional health authority or issuing qualified health professional of the Patient Advocate's investigation relating to that regional health authority or qualified health professional (section 5(4) of the Mental Health Patient Advocate Regulation).

9.6 Refusal to Investigate

The Patient Advocate may refuse to investigate or cease to investigate a matter if the Patient Advocate believes that the subject matter of the complaint is trivial, the complaint is frivolous or vexatious, no investigation is necessary having regard to all of the circumstances, or the subject-matter is more appropriately addressed by a different committee, body, person or other entity (section 9(1) of the Mental Health Patient Advocate Regulation).

The Patient Advocate may, with the consent of the complainant, attempt to resolve the complaint without an investigation (section 9(2)(a) of the Mental Health Patient Advocate Regulation). Referrals to a committee, body, person, or other entity with authority to investigate may be made with the consent of the complainant or the patient

to whom a matter or patient complaint relates (section 9(2)(b) of the Mental Health Patient Advocate Regulation).

9.7 Conduct of Investigation

The Patient Advocate has discretion about how to conduct the investigation.

- The Patient Advocate may make any inquiries that the Patient Advocate considers necessary (section 6(1)(b) of the Mental Health Patient Advocate Regulation).
- The Patient Advocate is authorized to make any contact with the patient and conduct any investigation the Patient Advocate considers necessary (section 6(1)(c) of the Mental Health Patient Advocate Regulation).
- The Patient Advocate is not required to hold a hearing (section 6(4) of the Mental Health Patient Advocate Regulation).

9.8 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 Patient Advocate (section 6(3) of the Mental Health Patient Advocate Regulation).

9.9 Conduct of Investigation; Cooperation by the Facility

Upon request, a facility, board, regional health authority or issuing qualified health professional must provide to the Patient Advocate within a reasonable time (section 11(1) of the Mental Health 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 or to whom an investigation relates.

If the board is notified of the Patient Advocate's intention to contact a patient, the board must grant the Patient Advocate access to the patient at all reasonable times (section 12(a) of the Mental Health Patient Advocate Regulation). The board must grant the Patient Advocate access to a formal patient at all reasonable times for all the purposes set out in section 45 of the Act (section 12(b) of the Mental Health Patient Advocate Regulation).

9.10 Confidentiality of Information Obtained During the Investigation

The Patient Advocate must not disclose information obtained during an investigation except as required by law or in the performance of the Patient Advocate's duties under the Act or Regulation (section 7 of the Mental Health Patient Advocate Regulation).

9.11 Record of Investigation

The Patient Advocate must maintain a record of every complaint and investigation (section 6(1)(a) of the Mental Health Patient Advocate Regulation).

9.12 Reporting at the End of an Investigation

The Patient Advocate must provide the board, regional health authority, or issuing qualified health professional with a copy of the Patient Advocate's investigation report (section 8(1) of the Mental Health Patient Advocate Regulation).

If the report contains recommendations, it must state the reasons for the recommendations (section 8(2) of the Mental Health Patient Advocate Regulation).

Should the Patient Advocate believe that the board, regional health authority, or issuing qualified health professional has not taken appropriate action within a reasonable time on any recommendation, the Patient Advocate must send a copy of the report and any response to the Minister (section 8(3) of the Mental Health Patient Advocate Regulation).

The Patient Advocate must inform a patient of the disposition of any patient complaint (section 10(a) of the Mental Health Patient Advocate Regulation).

The Patient Advocate may inform a complainant of the disposition of any complaint they initiate (section 10(b) of the Mental Health Patient Advocate Regulation).

The Patient Advocate may inform a patient of the disposition of any matter initiated without a complaint under section 4(1) of the Mental Health Patient Advocate Regulation that relates to the patient (section 10(c) of the Mental Health Patient Advocate Regulation).

9.13 Contact Information

The Patient Advocate can be contacted through the Office of the Alberta Health Advocates 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, except statutory holidays.

The address is 9th Floor, 10055 – 106 Street, Edmonton, Alberta T5J 2Y2.

9.14 Questions about the Mental Health Patient Advocate in Practice

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

Complaints and concerns may be communicated by phone, email, online inquiry form, in writing by mail, or in person by visiting the Patient Advocate's office in Edmonton.

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

Under section 14(1)(d) of the Act, if a formal patient requests to be contacted by the Patient Advocate, the board shall notify the Patient Advocate and provide the Patient Advocate with copies of the certificates and information. There is no specific timeline for this information to be communicated by the board to the Patient Advocate. Section 45(1.1)(a) provides the Patient Advocate shall contact the formal patient as soon as practicable after receipt of the certificates. Copies of materials requested by the Patient Advocate must be provided to the Patient Advocate within a 'reasonable time' (section 11 of the Mental Health Patient Advocate Regulation). The Patient Advocate provides timelines in the written notification letter advising the facility to supply the Patient Advocate with the required information.

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

3. **Can the Patient Advocate, when investigating designated 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 Patient Advocate's investigation. The Patient Advocate has broad discretion and can make inquiries that the Patient Advocate considers necessary to conduct an investigation (section 6(1)(b) of the Mental Health Patient Advocate Regulation and section 45(3) of the Act.)

4(a). A qualified health professional issues a Form 1 - Admission Certificate on a patient who is taken to a designated facility for examination. The patient subsequently lodges a complaint with the Patient Advocate. Can the Patient Advocate, in the course of an investigation, ask for information from the issuing qualified health professional?

Yes.

What information can be accessed?

The Patient Advocate is designated as a "custodian" under the HIA (section 2(1) of the Health Information Regulation). Health information may be disclosed by the qualified health professional that issued the Form 1 to the Patient Advocate pursuant to sections 35(1)(a) and 27(1)(f) of the HIA.

4(b). What if the patient's family, rather than the patient, asked the Patient Advocate to look into the admission of the patient as a formal patient?

Yes, section 45(1.1)(e) of the Act and section 1(b) and 3 of the Regulation do not specify that a complaint needs to be made by a patient, only that a complaint must be made relating to a patient.

APPENDIX I: Glossary

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 a qualified health professional who believes a person (section 1(1)(a) of the Act):

- is suffering from mental disorder,
- has the potential to benefit from treatment for the mental disorder,
- is, within a reasonable time, likely to cause harm to others or to suffer negative effects, including substantial mental or physical deterioration or serious physical impairment, as a result of or related to the mental disorder, and
- is unsuitable for admission to a facility other than as a formal patient.

An admission certificate may also be issued under section 3 of the Act for a person detained under the *Criminal Code of Canada* or *Youth Criminal Justice Act* (of Canada).

AGENT

This term is defined under section 1(1)(a) of the *Personal Directives Act* (Alberta) as a person designated in a personal directive to make decisions on behalf of a person who completes a personal directive.

These decisions may involve healthcare 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, King’s Printer, Laws Online Results website: https://kings-printer.alberta.ca/Laws_online.cfm. Once on the website, search by title for the *Personal Directives Act* or https://open.alberta.ca/publications/p06.

COMMUNITY TREATMENT ORDER (CTO)

An order issued by two qualified health professionals (one of whom must be a psychiatrist) if a person meets certain criteria and they 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 FACILITY

Correctional Facility is not defined in the Act.

In the *Corrections Act,* correctional institution is defined as:

(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 9.1 of the Act, dealing with CTOs), rather than a Correctional Facility. A Custodial Institution likely has a broader 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(1)(d) of the Act). In practice the term refers to inpatient health facilities which have been designated by the Minister pursuant to section 52(1.1) of the Act as the only places 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 Act Forms and Designation Regulation. A list of these facilities as of April 2021 is in Appendix II (section 15.2(1) of the Mental Health Forms and Designation Regulation 136/2004).

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, or permanent guardianship agreement,
- a guardian appointed under the *Adult Guardianship and Trusteeship Act* who has the authority to act and make decisions with respect to
  - the adult's health care
  - carrying on any legal proceeding that does not relate primarily to the estate of the adult.

Under the *Adult Guardianship and Trusteeship Act*

- An individual appointed by a court to make decisions for an adult, acting in their best interests, whose interests will not conflict with the adult's interests.
- A Guardian is appointed under the *Adult Guardianship and Trusteeship Act* where the Court is satisfied that an adult does not have capacity to make decisions about personal matters and other less intrusive measures would not likely be or have not been effective.
- Usually among the Guardian's powers and authorities is the power to consent to any health care that is in the adult's best interests.
- The *Adult Guardianship and Trusteeship Act* and its Regulations are located at the Government of Alberta, King's Printer, Laws Online Results website: https://kings-printer.alberta.ca/Laws_online.cfm. Complete a search by title: *Adult Guardianship and Trustee Act* or https://open.alberta.ca/publications/a04p2 .

MENTAL DISORDER

Mental disorder is defined as 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, **but does not include a disorder in which the resulting impairment is persistent and is caused solely by an acquired or congenital irreversible brain injury**. The change to the definition (bolded above) which took effect on March 31, 2021, is supported by definitions in section 2.1 of the Mental Health Regulation as follows:

(a) "irreversible brain injury" means a permanent disruption to the baseline function of the brain or to the structure of the brain caused or likely caused by an identifiable or probable

(i) acute external action, including trauma, or

(ii) pathophysiological event within the body, including an acute hypoxic event, but does not include a permanent disruption caused or likely caused by a neurodegenerative disorder;

(b) "persistent" means stable and unlikely to improve as a result of treatment.

MINISTER

Minister means the Minister of Health, who has been designated under section 16 of the *Government Organization Act* as the Minister responsible for the *Mental Health 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.

PEACE OFFICER

Although the *Mental Health Act* does not define "peace officer", the *Police Act* and *Peace Officer Act* do. The Minister responsible for both statutes is the Minister of Justice and Solicitor General.

Section 7 of the *Peace Officer Act* provides that the Minister of Justice and Solicitor General can appoint a person as a peace officer to hold broad or limited authorities, dependent on job functions.

PERSONAL DIRECTIVE

A legal document that sets out advanced personal instructions for an individual, and which may designate a person to make decisions on behalf of the individual, 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, King's Printer, Laws Online Results: https://kings-printer.alberta.ca/Laws_online.cfm. Complete a search by title: *Personal Directives Act* or https://open.alberta.ca/publications/p06.

PUBLIC GUARDIAN

The person appointed as the Public Guardian pursuant to the *Adult Guardianship and Trusteeship Act*.

Under section 107 of the *Adult Guardianship and Trusteeship 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.

The website reference is located at the Government of Alberta, King's Printer, Laws Online Results: https://kings-printer.alberta.ca/Laws_online.cfm. Complete a search by title: *Adult Guardianship and Trusteeship Act*

QUALIFIED HEALTH PROFESSIONAL

The Minister may designate in the future other qualified health professionals under the regulations but at the time of publication of the guide, a qualified health professional is a psychiatrist, physician, or nurse practitioner.

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 and is the only regional health authority.

A copy of this Act can be found on the Government of Alberta, King's Printer, Laws Online Results website: https://kings-printer.alberta.ca/Laws_online.cfm. Complete a search by title: *Regional Health Authorities Act* or https://open.alberta.ca/publications/r10.

RENEWAL CERTIFICATE

A certificate issued pursuant to section 8 of the Act (section 1(1)(o) of the Act). This provides a mechanism for extending a formal patient's period of detention, after **two** qualified health professionals who have separately examined a formal patient, believe that formal patient meets the criteria and requires continuing psychiatric care. At least one of the qualified health professionals who issue renewal certificates must be a member of the staff of the designated facility at which the formal patient is detained and at least one of the renewal certificates must be issued by a psychiatrist (section 8(2) of the Act).

REVIEW PANELS

Three-member panels 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 facility (section 33 of the Act),
- to review/cancel admission certificates or renewal certificates or for an order for the board to issue a CTO (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. Although the term SDM is never used in the Act, it is used in practice. Section 28 of the Act specifies who may be an 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 an SDM (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".

APPENDIX II: List of Designated Facilities

List of Designated Facilities

15.2(1) The following places are designated as facilities for the purposes of section 1(1)(d) of the Act:

(a) Alberta Hospital Edmonton;

(b) Centennial Centre for Mental Health and Brain Injury;

(c) Peter Lougheed Centre;

(d) Foothills Medical Centre;

(e) Misericordia Community Hospital;

(f) Royal Alexandra Hospital;

(g) University of Alberta Hospital;

(h) Grey Nuns Community Hospital;

(i) Chinook Regional Hospital;

(j) Medicine Hat Regional Hospital;

(k) Northern Lights Regional Health Centre;

(l) repealed;

(m) Rockyview General Hospital;

(n) Claresholm Centre for Mental Health and Addictions;

(o) Red Deer Regional Hospital Centre;

(p) Southern Alberta Forensic Psychiatry Centre;

(q) St. Therese - St. Paul Healthcare Centre;

(r) Villa Caritas;

(s) South Health Campus;

(t) Alberta Children’s Hospital;

(u) Stollery Children’s Hospital;

(v) Grande Prairie Regional Hospital.

(**2**) The following places are designated as facilities for the purposes of section 1(1)(d) of the Act, only for the purposes of section 13 of the Act:

(a) Helen Hunley Forensic Pavilion at Alberta Hospital Edmonton;

(b) Southern Alberta Forensic Psychiatry Centre.

(**3**) The following places are designated as facilities for the purposes of section 1(1)(d) of the Act, except for the purposes of sections 4(1)(a), 9.6, 10, 12 and 24 of the Act:

(a) Glenrose Rehabilitation Hospital;

APPENDIX III: Mental Health Act Forms

Electronic versions of all the *Mental Health Act* forms are available on the Alberta Health Services website at https://www.albertahealthservices.ca/info/page1256.aspx . 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 2.1:	Cancellation of Admission Certificate or Renewal Certificate (section 31(4) 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 Review Panel Regarding Admission Certificates, Renewal Certificates, or Community Treatment Orders (sections 38(1), 38(1.1) and 41 of the Act)

Form 17.1 Decision of Review Panel Regarding Order for the Board to Issue a Community Treatment Order (sections 38(1)(b) and 41 of the Act)

Form 18: Decision of Review Panel Regarding Renewal Certificates and Community Treatment Orders (Deemed Application) (sections 39 and 41 of the Act)

Form 19: Issuance of 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, Non-compliance Report (section 9.1(2)(f) of the Act)

APPENDIX IV: Investigations that may occur within Designated Facilities

Note: the wording in this section has been taken from the following organizations' websites.

What does the Alberta Ombudsman do?

The Alberta Ombudsman responds to complaints of unfair treatment by provincial government authorities, municipalities, the Patient Concerns Resolution Process of Alberta Health Services, health professions and other designated professional organizations.

The Alberta Ombudsman's website is https://www.ombudsman.ab.ca/.

Protection for Persons in Care

Protection for Persons in Care requires the reporting of abuse of adult clients receiving care in publicly funded facilities.

The Protection for Persons in Care website is https://www.alberta.ca/protection-for-persons-in-care.aspx.

APPENDIX V: Qualified Health Professionals Roles under the Mental Health Act

MHA Forms completions by Qualified Health Professionals	Psychiatrist	Physician	Nurse Practitioner
Form 1 - Issuance of Admission Certificate One of whom must be a psychiatrist	✓	✓	✓
Form 2 - Issuance of Renewal Certificate One of whom must be a psychiatrist	✓	✓	✓
Form 2.1 - Cancellation of Admission or Renewal Certificate	✓	✓	
Form 3 - Order to Return a Formal Patient to a Facility	The responsibility of the "board" is delegated, and may be delegated to any of these three groups -		
Form 11 Certificate of Incompetence to Make Treatment Decisions	✓	✓	
	- If a formal patient who is competent or the substitute decision-maker object to treatment, then the QHP shall not administer treatment without a treatment order (issued by the review panel)		
Form 19 & 20 - CTO Issuance & Renewal One of whom must be a psychiatrist	✓	✓	✓
Form 21 - CTO Amendment One of whom must be a psychiatrist	✓	✓	✓
Form 22 CTO Cancellation	✓		
Form 22 CTO Expiry	✓	✓	✓
Form 23 CTO Apprehension Order	✓	✓	✓
Form 24 CTO Examination on Apprehension One of whom must be a psychiatrist	✓	✓	✓

Qualified Health Professional (QHP) as defined by the Act “qualified health professional” means a psychiatrist, physician, nurse practitioner, or a person who is registered under section 33(1)(a) of the *Health Professions Act* as a member of a health profession or of a category within a health profession designated by the regulations for the purposes of all or part of the Act.