



Northwest Territories' *Mental Health Act*

**Applying the *Mental Health Act*
Case Studies**

Part 1: Introduction to Sam

Age: 22

DOB: September 1, 1995

Community: Small community in the NWT

Sam is 22 years old and has been away working in Alberta in the oil and gas industry. He returned home 6 months ago after being laid off. He had worked in Alberta for the past 3 years, and rarely returned home.

Since coming home, Esther (Sam's mother) notices that he has been quiet, withdrawn from the family (isolating himself) and she has noticed some strange behaviours. Sam has been moving things around the house, and she thinks he is talking to himself. He tends to keep to himself in his room, and he has expressed that there are people "out to get him." Esther has also noticed that he does not take care of himself very well – he rarely showers or changes his clothes, sometimes forgets to eat and doesn't sleep through the night. She is worried about him.

Esther talks with Sam and he agrees to go with her to the health centre.

Sam and his mother enter the Health Centre. Esther tells the nurse that her son is acting "strangely" since he has returned home. He is speaking out of context, having trouble sleeping, being guarded and unwilling to answer any questions. He started speaking to himself and acting bizarrely around the house, covering the windows, turning the mirrors to face the wall, or covering his head. He has become more suspicious and has started to become more aggressive towards his family. Esther made sure the other kids in the house went to her sister's to be safe, but she is concerned for Sam's safety.

Sam has no previous psychiatric history.

The Community Health Nurse (CHN) at the Health Centre states that Sam has done the right thing by coming in and that she will complete an assessment. When the nurse talks to Sam, he says he is scared; he does not feel 'right'. He identified he has been drinking to see if he can get rid of the voices. He tells the nurse he is scared about what he might do to himself and others.

The CHN at the Health Centre knows the family but has not had any previous contact with Sam. She examines Sam and decides there is enough information to support completion of Form 2 – *Certificate of Involuntary Assessment*. The CHN also goes through Form 1 – *Notification of Patient Rights and Other Information* with Sam and explains to Sam he should go to a designated facility for further assessment. Sam is upset and one moment he agrees to travel to get help, and the next he is threatening to leave and becomes very agitated. Sam refuses to take medication that will help him relax during travel to the designated facility.

The RCMP are asked to convey Sam to Stanton Territorial Hospital, a designated facility. They ask the nurse to fill out Form 10 – *Summary Statement Respecting Apprehension or Conveyance*.

ACTIVITY: Refer to **Form 2 – Certificate of Involuntary Assessment**.

Discussion:

Using the information provided, please complete Form 2. Work in pairs. Review and discuss – are there any questions? Any difficulties?

AWARENESS NOTE: Point out the **Distribution Note** and **Additional Actions Required on Form 2**.

Reinforce the need to ensure each time **any** form is issued, the distribution and/or additional actions are to be followed.

Refer to Form 1 – Notification of Patient Rights and Other Information and Patient Rights Poster. Are there any other questions about this form? This is an important form to be familiar with.

Hand out Form 10 – Summary Statement Respecting Apprehension or Conveyance. As a group, discuss how to fill this out, what information would be included that would be helpful for the person conveying the patient.

Sample: Completed Form 2



FORM 2 – Northwest Territories Mental Health Act
CERTIFICATE OF INVOLUNTARY ASSESSMENT

This certificate authorizes the apprehension of a person by a peace officer, and the conveyance of that person by a peace officer or other authorized person to the specified designated facility for **up to 7 days after the certificate is issued**. Once at the facility, this certificate authorizes the involuntary care, observation, examination, assessment, and treatment of that person for **up to 72 hours**. It further authorizes the detention and control of the person for these purposes.

** Note: this certificate must be issued within 24 hours of completing the examination.*

Name of Person Sam		Gender Male
Health Care Number XXXXXX		Date of Birth (DD-MM-YYYY) 01-09-1995
Address of Person (community of residence at time of examination)		
Street	Community Small Community	Postal Code
Facility (where examined)		
Name Small Community Health Centre		
Street	Community	Postal Code

TO BE COMPLETED BY HEALTH PROFESSIONAL ISSUING CERTIFICATE	
I, _____, a Community Health Nurse , personally examined	
<small>(Name of Health Professional)</small>	<small>(Health Profession)</small>
Sam	of Small Community
<small>(Full Name of Person)</small>	<small>(Community)</small>
on 05-05-2018	at 10:30
<small>(DD-MM-YYYY)</small>	<small>(Time)</small>
In my professional opinion, the person:	
<input checked="" type="checkbox"/> (a) is suffering from a mental disorder;	
(b) because of the mental disorder, the person	
<input checked="" type="checkbox"/> (i) is likely to cause serious harm to themselves or to another person, or to suffer substantial mental or physical deterioration, or serious physical impairment,	
OR	
<input type="checkbox"/> (ii) has recently caused serious harm to themselves or to another person, or has threatened or attempted to cause such harm;	
AND	
<input checked="" type="checkbox"/> (c) the person should undergo an involuntary psychiatric assessment to determine whether they should be admitted to a designated facility as an involuntary patient.	

The person must meet the criteria outlined in sections a, one of b (i) or (ii), and c for the health professional to issue the certificate.

The following information supports my opinion that the person meets the criteria as checked above:
Facts personally observed during examination: Sam is a 22 year old male, who presented at clinic with his mother. Patient appeared disheveled in his dress, unkempt, exhibits poor hygiene. Minimal eye contact, presented as withdrawn and quiet in manner. Upon further questioning, he stated he is scared, he does not "feel right". Did not elaborate on that statement He identified he has been drinking "to see if he can get rid of the voice"; amount not given. He is "scared about what he might do to himself or others". There is no previous psychiatric history.
Facts communicated by others/other information: Mother stated she noticed since Sam returned home (has been working in Alberta for the past 3 years) he has been withdrawn from the family, isolating himself. She notices some strange behaviours, such as moving things around the house and talking to himself. He tends to stay in his room, and has said other people are "out to get him". He does not take care of himself, rarely showers or changes his clothes. He sometimes forgets to eat, doesn't sleep through the night. He covers the windows, turns the mirrors to face the wall or covers his head. He has become more suspicious and is becoming more aggressive with his family. She stated she is afraid of what he might do.

The person named in this certificate:														
<input type="checkbox"/> Is already at a designated facility and will receive an involuntary psychiatric assessment at the facility where they are currently located.														
OR														
<input checked="" type="checkbox"/> Requires apprehension and conveyance to a designated facility to receive an involuntary psychiatric assessment, as outlined below:														
Designated Facility where person is to be conveyed for involuntary psychiatric assessment														
Name Stanton Territorial Hospital														
Street	Community Yellowknife	Postal Code												
Expiration of Authority to apprehend and convey (*7 days after issuance of certificate)														
Date (DD-MM-YYYY) 12-05-2018	Time 10:30													
<table border="1"> <tr> <td>XXXXXXX</td> <td>X</td> <td>PLEASE PRINT FORM TO SIGN</td> </tr> <tr> <td>Printed Name of Health Professional</td> <td>Signature</td> <td></td> </tr> <tr> <td colspan="3">Dated this 5th day of May, 20 18 at 10:30 .</td> </tr> <tr> <td colspan="3" style="text-align: center;">(Time)</td> </tr> </table>			XXXXXXX	X	PLEASE PRINT FORM TO SIGN	Printed Name of Health Professional	Signature		Dated this 5th day of May , 20 18 at 10:30 .			(Time)		
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Dated this 5th day of May , 20 18 at 10:30 .														
(Time)														

Distribution Note:

- This form must be filed with the director of the designated facility where the person is to receive an involuntary psychiatric assessment.
- Copies need to be provided to the patient, and if applicable:
 - (a) Substitute decision maker
 - (b) Person designated by patient to receive information
 - (c) A person with lawful custody or authority if the patient is a minor
 - (d) Legal guardian
 - (e) Agent under a personal directive
 - (f) Relative (with patient's consent if (a) to (e) do not apply)

Additional Actions Required:

- A *Summary Statement Respecting Apprehension or Conveyance* may be required by the peace officer or other authorized person responsible for apprehension and/or conveyance.
- Complete *Notification of Patient Rights and Other Information* form at **earliest opportunity**.

The personal health information on this form is being collected under the authority of the *Mental Health Act*. It is protected by the privacy provisions under the *Health Information Act* (HIA) and will not be used or disclosed unless allowed or required by the HIA or any other Act. If you have any questions about this form, please contact the Clinical Mental Health Program Specialist at 867-767-9061 ext. 49164 or mentalhealth_act@gov.nt.ca

If you would like this information in another official language, contact us at 1-855-846-9601. / Si vous voulez ces informations dans une autre langue officielle, téléphonez-nous au 1-855-846-9601.

Part 2: Involuntary Assessment

Sam is admitted to the Psychiatry Unit at Stanton. He is examined by the medical practitioner. The medical practitioner knows that Form 2 allows for Sam to be held on the unit at Stanton for up to 72 hours for observation and assessment.

The medical practitioner explains to Sam that during the next 72 hours the nurses and doctors will be speaking with him and determining the best way to help. Sam is aloof and will not provide much information to the medical practitioner.

Sam's grandmother, Josephine has contacted the Health Centre several times to get information about how her grandson is doing. The Community Health Nurse explains to Josephine that because Sam is an adult, the amount of information they can share is limited. The nurse contacts Stanton and asks the staff on Psychiatry to see if Sam will agree to have a Form 6 – *Designation of Person to Receive Information* completed so that information can be provided to his grandmother. Then the nurses at Stanton will be able to give Josephine more information.

Sam agrees to have information provided to his grandmother. He fills out a Patient Release of Information Form as well as Form 6 – *Designation of Person to Receive Information*.

Form 6 allows Sam's grandmother to receive any of the certificates that are checked off on the form, as well as any other specific documents identified on the form.

Part 3: Involuntary Assessment to Involuntary Admission

The psychiatrist meets with Sam in the morning. Sam is a bit more alert - he is scared and wants to go home. He discloses that he has been hearing voices, using drugs and alcohol to see if he can get rid of the voices. He admits he would like to die but has no plans to kill himself. He does not know how to stop feeling this way. He is sad because he knows this is causing stress for his mother and family and feels like he is a burden.

The psychiatrist (attending medical practitioner) performs the psychiatric assessment over the next 48 hours. The 72 hours allotted to provide treatment, care, and assessment started once Sam arrived at Stanton, the designated facility, the morning prior. The attending medical practitioner collects more information on Sam's history and current mental health status. The attending medical practitioner feels Sam would do well with time as a patient on the unit, to help him become more stabilized, and find the right treatment and supports to help reduce his anxiety, calm the voices and become less agitated.

Sam does not want to stay at the hospital, he is still aggressive towards others and several signs and symptoms point to a more chronic mental disorder. The psychiatrist completes Form 3 - *Certificate of Involuntary Admission*. She explains to Sam that it is very important that he receives help, and it will take more time in hospital. The psychiatrist provides Sam with information about his rights and the reasons for his involuntary admission.

ACTIVITY: Review **Form 3 – Certificate of Involuntary Admission**. Discuss the various areas that need to be completed and refer to the Distribution Note and Additional Actions Required at the end of the Form.

Remind everyone that Form 1 – *Notification of Patient Rights and Other Information* is again given to and reviewed with the patient.

Hand out Flow Chart 3: Involuntary Assessment and Admission

Review the steps as identified on the flow chart. Allow time for questions and discussion.

Part 4: Mental Competence and Treatment Decisions

As soon as Sam is admitted to Stanton, the psychiatrist assesses Sam's ability to manage his estate and to make treatment decisions. The medical practitioner believes that Sam is capable of making decisions regarding his estate, but he is unable to describe the benefits or consequences of refusing treatment. Therefore, Sam needs a substitute decision maker. This is someone who can help with treatment decisions and advocate for Sam while in hospital. Sam does not have a legal guardian or agent, and feels his mother would be the best person to make decisions about his treatment and medications.

Form 11 – *Treatment Decision Certificate* is completed by the attending medical practitioner. This specifies that Sam has been assessed and it has been determined the he is not capable of making his own treatment decisions. Once Form 11 is issued, the attending medical practitioner (or the director of the designated facility) seeks out a person to act in this role.

Esther is contacted by the nurse at the Health Centre to ask her if she would be Sam's substitute decision maker. A call is arranged between the attending medical practitioner, Esther and the nurse to talk about the role of a substitute decision maker. Esther understands her role as the substitute decision maker and signs Form 12 – *Designation of Substitute Decision Maker*.

Refer to Forms 11 and 12 for additional information.

The form is faxed to Stanton. Sam, the attending medical practitioner and Esther have a teleconference to discuss counselling and treatment options, including medications. Esther asks questions about side effects, types of activities Sam could be involved in, and the support he will receive. She agrees on the course of treatment.

Esther is kept informed of Sam's progress.

Case Study: If Sam's mother refused to be his substitute decision maker, who would be the next choice?

Part 5: Renewal Certificate

Sam is now approaching 27 days in the hospital – he is getting tired of being there and wants to go home. His attending psychiatrist performs an assessment prior to Form 3 - *Certificate of Involuntary Admission* expiring (72 hours prior). He has made progress and is working hard with his health care providers and taking his medications. The psychiatrist determines that Sam still meets the criteria of an involuntary admission under the Act. He also does not wish to stay as a voluntary patient at the hospital. She explains that Sam will continue to be an involuntary patient under the Act and provides him with his rights. She completes Form 4 – *Renewal Certificate* and ensures she reviews his rights.

ACTIVITY: Review Form 4.

Part 6: Cancellation of Certificate of Involuntary Admission or Renewal Certificate

The attending medical practitioner has examined Sam within the past 72 hours. She has determined that Sam no longer meets the criteria for an involuntary admission. Sam has been offered the option of staying as a voluntary patient or going back to his home community. The attending medical practitioner issues Form 5 – *Cancellation of Certificate of Involuntary Admission or of Renewal Certificate*. The discharge plan has been created and Sam is on his way home, with supports and follow up in place. Sam is no longer an involuntary patient under the *Mental Health Act*.

Part 7: Assisted Community Treatment

Beth

Age: 54

DOB: January 15, 1964

Community: Yellowknife

Beth has an extensive history of previous admissions to the Psychiatric Unit at Stanton. During this current admission, she has been improving on new medications - she feels much better and feels that she should leave the hospital. She has been granted short term leave three times since she was admitted. It has been almost 58 days since she was admitted. The psychiatrist has assessed Beth and believes that she still meets the criteria for involuntary admission under the *Mental Health Act*. A new Form 4 – *Renewal Certificate* is issued before the current Form 4 expires.

The psychiatrist tells Beth that she has two choices:

1. Beth can remain as a patient, in Stanton, or
2. Receive treatment in the community, under assisted community treatment.

The psychiatrist feels Beth will do well in the community, under assisted community treatment. Beth would like that as well.

Step 1:

The psychiatrist talks to Beth about planning for her to live in the community. They would ensure there are adequate supports and treatment options available. She agrees she would like to leave the hospital and is willing to participate in the *Community Treatment Plan* as it is developed.

Step 2:

The psychiatrist provides the director of the designated facility Form 21 – *Notice of Intention to Issue Assisted Community Treatment Certificate*, within 72 hours before issuing Form 22 – *Assisted Community Treatment Certificate*.

Step 3:

The psychiatrist and social worker meet with Beth to discuss her goals for assisted community treatment. They discuss the resources in the community, and Beth's informal and formal supports.

The social worker asks Beth to sign the *Community Treatment Plan – Patient Consent* form, so that they can contact the community supports, including health professionals. This form provides consent for Beth's personal and/or personal health information being shared to determine whether her situation is suitable for participation in assisted community treatment. Beth signs the form and feels better that she is moving towards going home.

The social worker and Nurse Practitioner from Primary Care, Beth, and her sister, Mabel (who is deemed her substitute decision maker) have a meeting to discuss formal supports in the community. The Nurse

Practitioner discusses that she is willing and able to help Beth when she is ready to return home. There are also counselling and community wellness programs available to Beth. Mabel states that their cousin misses Beth and enjoys playing board games, as she can't get out of the house often due to health concerns. Beth also identified previous volunteer experiences she had in the past, and willingness to resume those activities.

The social worker and Beth make calls to other potential people and report this to the psychiatrist. Beth was very happy to see so many people were interested in helping her and is eager to go home. Mabel has agreed that Beth can live with her, and the social worker and Beth have contacted income support.

Step 4:

The psychiatrist acknowledges that Beth has done a great deal of work and that the social worker, Nurse Practitioner and Mabel are confident that the supports in the community can help Beth if she goes home. *Community Treatment Plan – Consent of Monitor* and *Community Treatment Plan – Consent of Provider* is signed by all her community supports. This allows for sharing of information between team members (providers and monitors). The psychiatrist completes Form 22 – *Assisted Community Treatment Certificate* and Form 23 – *Community Treatment Plan*. A final assessment is completed within 72 hours of issuing Form 22.

The psychiatrist explains to Beth that Form 22 - *Assisted Community Treatment Certificate* means that she is still an involuntary patient, but that she can live at home.

Beth and Mabel both sign Form 22 and Mabel signs Form 23.

Step 5:

Before Mabel leaves the hospital, the social worker decides to have a teleconference with everyone who has agreed to be a part of the *Community Treatment Plan*. Beth hears what each person is prepared to help with, and she agrees to keep her commitments identified in the plan, like take her medication, let the Nurse Practitioner know if there are problems, and participate in several other activities like going to the Baker Centre for Tai Chi classes.

The signed Form 22 - *Assisted Community Treatment Certificate* and Form 23 - *Community Treatment Plan* are sent to all the people who have agreed to be a part of the *Community Treatment Plan*, including Beth.

Beth is reminded that Form 22 - *Assisted Community Treatment Certificate* is valid for six months.

Health professionals and other named individuals are to advise the medical practitioner responsible for the supervision of Form 23 - *Community Treatment Plan* within 24 hours if the patient is not complying with the plan. The frequency of reporting (via Form 24) is included in the *Community Treatment Plan – Consent of Provider* form.

Part 8: Mental Health Act Review Board

Beth feels she is doing well and would like to be discharged as an involuntary patient. She feels she has been working to meet all the goals identified in the *Community Treatment Plan*. She decides that she is going to apply to the Mental Health Act Review Board.

Step 1:

Beth calls the Mental Health Act Review Board and asks for an application form. The Office Manager emails a copy of Form 19 – *Application to Review Board* to Beth, and explains the areas of the form that need to be completed. Beth checks the box that requests cancellation of Form 4 – *Renewal Certificate* (*Cancel Certificate of Involuntary Admission or Renewal Certificate to release patient back to community*). Beth walks to the Mental Health Act Review Board office, and hand delivers the application to the Office Manager.

Step 2:

A review panel is named.

Within 48 hours of delivering the application, Beth receives notification from the Review Board stating that a hearing will be held within 14 days. This notice is also provided to both her psychiatrist, and the medical practitioner responsible for supervision of the *Community Treatment Plan*, her substitute decision maker and the director of Stanton (the designated facility where she is admitted).

Step 3:

Seven days before the hearing occurs, notice is provided to all parties, including Stanton regarding the date, time, place and purpose of the hearing. The review panel may request the medical records of Beth.

Step 4:

The hearing is held at Stanton.

Step 5:

On the day of the hearing, Mabel and Beth arrive at Stanton. They enter the room with the psychiatrist and medical practitioner who has been responsible for Beth's care in the community (if different). The review panel chair explains what happens at the hearing:

That Beth and the medical practitioners can speak and then the review panel will ask questions. After everyone leaves, the review panel will make a decision, and Beth, the psychiatrist and the substitute decision maker, as well as the director of the designated facility will receive a notice of the decision within 48 hours.

Step 6:

The review panel decides that Beth has made a great deal of progress with her treatment. They acknowledge that Beth does not want to remain as an involuntary patient, however, she continues to meet the criteria for involuntary admission under the *Mental Health Act*. They explain that Beth can apply to the Review Board in 30 days if she is still an involuntary patient or she can submit an appeal to the Supreme Court of the Northwest Territories within 30 days.