Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

**FORM 22 – *Northwest Territories Mental Health Act***

# ASSISTED COMMUNITY TREATMENT CERTIFICATE

This *Assisted Community Treatment Certificate* must be accompanied by a ***Community Treatment Plan*.**

| Name of Patient | | Gender |
|---|---|---|
| Health Care Number | | Date of Birth (DD-MM-YYYY) |
| **Address of Patient** | | |
| Street | Community | Postal Code |
| **Designated Facility** (where admitted) | | |
| Name | | |
| Street | Community | Postal Code |

**The person subject to this certificate will remain *involuntarily admitted* to the designated facility, even if they are residing outside of the facility grounds.**

| **Current Involuntary Admission or Renewal Certificate** | **Date of Issue (DD-MM-YYYY)** | **Time of Issue** | **Name of Attending Medical Practitioner who Issued Certificate** | **Date of Expiry (DD-MM-YYYY)** | **Time of Expiry** |
|---|---|---|---|---|---|
| *Certificate of Involuntary Admission* | | | | | |
| **OR** *Renewal Certificate* | | | | | |

This certificate is the _____ *Assisted Community Treatment Certificate* being issued (please select one):

☐ Original ☐ 1st Renewal ☐ 2nd Renewal ☐ 3rd Renewal ☐ _____ Renewal (please indicate)

| **Previous Assisted Community Treatment (ACT) Certificates** | **Date of Issue (DD-MM-YYYY)** | **Time of Issue** | **Name of Medical Practitioner who Issued Certificate** |
|---|---|---|---|
| Original ACT Certificate | | | |
| ACT Certificate Renewal 1 | | | |
| ACT Certificate Renewal 2 | | | |
| ACT Certificate Renewal 3 | | | |
| ACT Certificate – Subsequent Renewal | | | |

** All previous consecutive renewals must be listed. Each certificate/renewal is not to exceed 6 months. Attach additional page if more space is needed.*

## TO BE COMPLETED BY ATTENDING MEDICAL PRACTITIONER ISSUING CERTIFICATE

I, _____ of _____,
(Attending Medical Practitioner) (Address)

have personally examined _____ within the past 72 hours, on _____ _____.
(Patient Name) Date (DD-MM-YYYY) Time

**In my opinion, the patient named in this Certificate meets the criteria for an *Assisted Community Treatment Certificate*:**

- ☐ The patient is suffering from a mental disorder for which the patient is in need of supervision and treatment or care that can be provided while the patient resides outside the designated facility;
- ☐ If the patient does not receive supervision and treatment or care while residing outside the designated facility, he or she is likely, because of the mental disorder, to cause serious harm to himself or herself or another person or to suffer substantial mental or physical deterioration, or serious physical impairment;
- ☐ The patient is capable of complying with the requirements for supervision and treatment or care included in the *Community Treatment Plan*;
- ☐ The patient is willing to comply with the requirements for supervision and treatment or care included in the *Community Treatment Plan*; and
- ☐ Adequate treatment, services and support are available and will be provided to the patient.

**The following information supports my opinion that this patient meets the criteria as outlined above:**

Facts personally observed during examination:

Facts communicated by others/other information:

The following information must be considered while the involuntary patient is released on Assisted Community Treatment:

- While on the *Assisted Community Treatment Certificate* the patient will remain as an involuntary patient of _____ . (Designated Facility)
- This Certificate must be accompanied by a *Community Treatment Plan*.
- An *Assisted Community Treatment Certificate* may be issued for a period not exceeding 6 months and may be amended or renewed according to the *Assisted Community Treatment Regulations*.
- If there are changes to the *Assisted Community Treatment Certificate,* an *Assisted Community Treatment Certificate Amendment* must be completed.
- If there are changes to the *Community Treatment Plan,* a *Community Treatment Plan Amendment* must be completed.
- If there is a change in the mental condition of the patient or the patient requires supervision and treatment or care in a designated facility or there is a change in adequacy of treatment or supports available in the community where the person under this Certificate is residing, the Supervising Medical Practitioner may require the person to return to the designated facility.
- **This Certificate is automatically cancelled if the person named in this certificate is no longer an involuntary patient under a *Certificate of Involuntary Admission* or *Renewal Certificate*.**
- **The expiry date for current *Assisted Community Treatment Certificate* is** _____ _____ . Date (DD-MM-YYYY) Time

_____ X _____ PLEASE PRINT FORM TO SIGN

Printed Name of Attending Medical Practitioner | Signature

Dated this _____ day of _____, 20 _____ at _____ . (Time)

_____ X _____

Printed Name of Patient Subject to the Certificate | Signature

Dated this _____ day of _____, 20 _____ at _____ . (Time)

_____ X _____

Printed Name of Substitute Decision Maker (if applicable) | Signature

Dated this _____ day of _____, 20 _____ at _____ . (Time)

**Distribution Note:**

- This form, with the appended *Community Treatment Plan*, must be filed with the director of the designated facility where the patient is admitted involuntarily **within 24 hours**.
- Copies of this form, with copies of the appended *Community Treatment Plan*, 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:**

- Complete *Community Treatment Plan* and append to this certificate.

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 or mhact_reviewboard@gov.nt.ca