FORM 23 – *Northwest Territories Mental Health Act*

COMMUNITY TREATMENT PLAN

This *Community Treatment Plan* must be attached to the ***Assisted Community Treatment Certificate***.

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
Attending Medical Practitioner preparing *Community Treatment Plan*		
Name		
Street	Community	Postal Code
Contact Number	Email Address	
If different, Medical Practitioner responsible for general supervision and management of *Community Treatment Plan* (Supervising Medical Pracitioner)		
Name		
Street	Community	Postal Code
Contact Number	Email Address	

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*					

PART 1. TREATMENT PLAN

The patient must participate in the *Community Treatment Plan* and notify the Supervising Medical Practitioner or designate if there are problems with the plan or any problems participating in the plan.

A. Required Assessments

The patient must attend assessments at the dates, times, and locations as agreed to between the patient and the Supervising Medical Practitioner:

- Assessments to examine effectiveness of *Community Treatment Plan* and compliance:
  - Within 30 days from release from designated facility ("First Assessment")
  - Within 30 days of First Assessment ("Second Assessment")
  - Within 72 hours before expiry of *Assisted Community Treatment Certificate* or renewal of the Certificate ("Third Assessment")
  - At reasonable ongoing basis as required by supervising medical practitioner ("Additional Assessment")
  - At reasonable request of patient, substitute decision maker, or other person/body named in the plan ("Additional Assessment")
- Psychiatric assessments required for involuntary patients under the *Mental Health Act* ("Psychiatric Assessments")

	Date (DD-MM-YYYY)	Time	Location
First Assessment (<30 days from release)			
Second Assessment (<30 days from First Assessment)			
Third Assessment (<72hrs before expiry)			
Additional Assessment(s) (if known)			
Psychiatric Assessments			

B. Supervision, Treatment, Care, and/or Support Arrangements

The following outlines the supervision, treatment, care, and/or support(s) arranged for the patient:
**Attach additional page if more space is required.*

Name of Provider	Telephone
Other Contact Information	

☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): _____

Profession/Role

Description of treatment or care:

Location (if applicable)
**subject to change based on clinical need*

Frequency (if applicable)
**subject to change based on clinical need*

Name of Provider	Telephone
Other Contact Information	

☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): _____

Profession/Role

Description of treatment or care:

Location (if applicable)
**subject to change based on clinical need*

Frequency (if applicable)
**subject to change based on clinical need*

Name of Provider	Telephone
Other Contact Information	
☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): _____	
Profession/Role	
Description of treatment or care:	
Location (if applicable) **subject to change based on clinical need*	
Frequency (if applicable) **subject to change based on clinical need*	

C. Monitoring Arrangements

The following outlines monitoring support(s) arranged for the patient:
**Attach additional page if more space is required.*

Name		Telephone
Street	Community	Postal Code
Other Contact Information		
☐ Substitute decision maker ☐ Family member (specify): _____ ☐ Other (specify): _____		
Description of monitoring:		

Name		Telephone
Street	Community	Postal Code
Other Contact Information		
☐ Substitute decision maker ☐ Family member (specify): _____ ☐ Other (specify): _____		
Description of monitoring:		

D. Additional Terms and Conditions

The patient must comply with the following additional terms and conditions (eg. medications, etc):
**Attach additional page if more space is required.*

PART 2. OTHER SUPPORTS

A. Housing

The patient must reside at the address listed below:

Street Address		
Mailing Address	Community	Postal Code
Phone Number	Email Address	

If additional supports have been determined to be necessary to maintain stable housing as listed above, please list these supports and contact information in the space below.
**Attach additional page if more space is required.*

B. Income

The patient must have the following source(s) of income in place while residing in the community:
**Attach additional page if more space is required.*

Resource/Agency/Contact	Statement of Stable Income

C. Other

The following additional supports are required:
**Attach additional page if more space is required.*

PART 3. PATIENT AGREEMENT

Patient or Substitute Decision Maker Initial	
	I consent to the terms and conditions of the *Assisted Community Treatment Certificate* and *Community Treatment Plan* and agree to the specified conditions.
	I agree to participate and comply with the entire plan outlined above.
	I agree to attend appointments with my medical practitioner for assessments at the dates, times, and locations agreed to.
	I understand that I remain an involuntary patient of the facility, even though I am on an *Assisted Community Treatment Certificate*, and that the *Certificate of Involuntary Admission/Renewal* under the *Mental Health Act* remains in effect.
	I understand that I continue to be an **involuntary patient** until such time as my *Certificate of Involuntary Admission* expires or is cancelled.
	I understand that I can voluntarily return to the designated facility prior to the expiration of the *Assisted Community Treatment Certificate*.
	I understand that I am **required** to return to the facility before my *Assisted Community Treatment Certificate* expires, unless it is renewed or I am no longer an involuntary patient.
	I understand that if the *Assisted Community Treatment Certificate* is cancelled, it means that I must immediately return to the facility after receiving notice of the cancellation, unless I am no longer an involuntary patient.
	I understand that the *Assisted Community Treatment Certificate* may be cancelled if: a) my mental condition changes, or because of other circumstances I require supervision and treatment or care in the facility; or b) services in the community become unavailable and suitable alternatives cannot be arranged.
	I understand that if I fail to return to the facility as required, I may be apprehended by a peace officer and be returned to the designated facility.
	I understand that failure to follow any of these conditions may result in the cancellation of this *Assisted Community Treatment Certificate* which means that I must return to the facility.
	I consent to my personal health information being shared with the persons and bodies named in this *Community Treatment Plan* for the purpose of my participation in the plan.

I, _____, have read and understand the above terms and conditions of the
(Name of Patient or Substitute Decision Maker)

Community Treatment Plan and the *Assisted Community Treatment Certificate* and agree to participate and comply with the *Community Treatment Plan* to the best of my ability.

_____ X _____

Printed Name of Patient or Substitute Decision Maker | Signature

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

PART 4. MEDICAL PRACTITIONER AGREEMENT

I _____ of _____ :
(Medical Practitioner) (Facility)

☐ will be responsible for the general supervision and management of the *Community Treatment Plan*.

☐ have consulted with and obtained a written agreement from the health professionals, persons, and/ or bodies named in part 1B of this *Community Treatment Plan* in respect of the performance of their roles and obligations. Such agreement includes consent to disclose each health professional, person, and body's name to any other person or body named in the *Community Treatment Plan*.*

☐ have consulted with and obtained a written agreement from the substitute decision maker, family members, or other persons named in Part 1C of this *Community Treatment Plan* in respect of the performance of their roles and obligations. Such agreement includes consent to disclose each substitute decision maker, family member, and other person's name to any other person or body named in the *Community Treatment Plan*.*

_____ X PLEASE PRINT FORM TO SIGN _____
Printed Name of Medical Practitioner Signature

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

**Attach all written agreements to the completed* Community Treatment Plan.

Distribution Note:

Within **24 hours** of issuing this form:

- It must be filed with the director of the designated facility where the patient is admitted involuntarily with the corresponding *Assisted Community Treatment Certificate*.
- A copy must be provided to the patient, and if applicable, the patient's substitute decision maker with the corresponding *Assisted Community Treatment Certificate*.

Copies of this form, with the corresponding *Assisted Community Treatment Certificate* need to be provided to, if applicable:

(a) Person designated by patient to receive information
(b) A person with lawful custody or authority if the patient is a minor
(c) Legal guardian
(d) Agent under a personal directive
(e) Relative (with patient's consent if (a) to (d) do not apply)

Additional Actions Required:

- Append to *Assisted Community Treatment Certificate*.
- Attach all written agreements to the completed *Community Treatment Plan*.

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