Guide to *The Mental Health Services Act*

Effective 2015

Version 1.0

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Government of Saskatchewan

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Chapter 1

INTRODUCTION TO THE GUIDE AND TO *THE MENTAL HEALTH SERVICES ACT*

Chapter 1 introduces the Guide to *The Mental Health Services Act* and introduces *The Mental Health Services Act (MHSA)* with amendments effective in 2015.

Guide to *The Mental Health Services Act*

1.1 Purpose of the Guide

The Guide to *The Mental Health Services Act* (Guide) has two purposes:

- making *The Mental Health Services Act* more understandable; and
- promoting consistent interpretation of the *Act* so that people who need involuntary mental health treatment receive help in a lawful, responsible and respectful manner.

People who may find the Guide useful include persons with lived experience, families, managers, physicians and other health care providers, advocacy organizations, police officers and other interested people.

1.2 Development of the Guide

- Significant amendments to the *MHSA* required a new Guide.
- This Guide replaces the 2002 "Reference Guide to *The Mental Health Services Act* and Mental Health Services Regulations of Saskatchewan."
- Input for the Guide was received from many professionals, persons with lived experience, family and other stakeholder perspectives.

1.3 Relationships: *Act*, Regulations, Guide

- The *Act* and Regulations including the prescribed forms are the law and must be followed.
- Regulations forms cannot be altered.
- Recommended forms, not in the Regulations, can be altered.
- The Guide is not the law but is intended to help interpret and implement the law.

1.4 Structure of the Guide

The Guide includes chapters and appendices (see Table of Contents). Both are important and serve different functions.

- **Chapters:** Following this introductory chapter the second chapter describes the amendments to the *MHSA* that came into effect in 2015. The remaining five chapters provide an overview of how the *MHSA*, as amended, addresses the many issues regarding treatment as an inpatient and an outpatient and protecting people's rights.
- **Appendices.** The appendices are designed to consolidate information found in various sections of the chapters.

1.5 Editing conventions

- Inserted comments in a direct quotation from an *Act* are in square brackets – [comment].
- Underlining in quoted legislation is for emphasis and not part of the *Act*.
- "s" stands for the section of an *Act*.
- "Regulation" precedes the number of the regulation to the *MHSA*.

1.6 Forms of the Guide

- An electronic copy is available on the saskatchewan.ca website.

1.7 Copying and downloading the Guide

- The Guide may be photocopied or scanned.
- The Guide can be downloaded from the website and installed on computers.
- There are no copyright issues.
- Forms under the Regulations must not be altered and are only available electronically through the Queen's Printer website.

1.8 Navigating the Guide – finding your way around

- Table of Contents is detailed.
- Section numbers of the *Act* are provided, as are references to Appendices.
- Amendments have been incorporated into the *Act*, but are indicated by "(New 2015)".

1.9 Limits of the Guide

- The Guide addresses primarily the *MHSA*, however there may be other laws that apply to a situation.
- There may be other options not discussed in the Guide which meet the requirements of the *MHSA*.
- In summarizing sections of the *Act*, details which may prove to be important in a particular case may be omitted. The *MHSA* itself and the Regulations must be consulted directly.
- Service issues are outside the scope of the Guide.
- The advice of a lawyer may be warranted.

1.10 Questions and suggestions

- The procedures for obtaining answers to questions about the *Act* have not changed. Use the chain of administration including regional legal advice.
- Suggestions for clarification or changes to the Guide can be directed to:

  Community Care Branch
  Ministry of Health
  Phone: 306-787-7239
  Email: info@health.gov.sk.ca

1.11 Relationships: *Act* and Regulations

- The *Act* and Regulations Form the law.
- *The Mental Health Services Act* includes the Regulations.
- Regulations provide information for implementing the *Act* and include the prescribed forms under the *Act*.
- Regulations are consistent with the *Act* and within the regulating power spelled out in the *Act*.
- Regulations including forms were amended in 2015 to reflect the *MHSA* amendments.

1.12 Coming into effect of the *MHSA* amendments

- At a date to be determined the *MHSA* amendments and Regulations including new forms will come into effect on the proclamation date.
- **New forms and procedures must be used from 12.01 am on the date the amendments come into effect.**

- "Old" forms (e.g. Form A) **may be valid** after the amendments come into effect but every effort must be made to use the new forms.
- Forms are available on the Queen's Printer website.
- Certificates that have been written before the proclamation date continue to be valid including Form Gs, Community Treatment Orders, and Long Term Detention Orders.

Introduction to *The Mental Health Services Act*

1.13 *MHSA* Purpose

The primary purpose of the *MHSA* is to assist people suffering from serious mental illnesses in receiving treatment. In some cases, people with serious mental illnesses are not able to make informed decisions about their treatment due to their mental state, but without treatment are likely to cause harm to themselves or others, or suffer serious deterioration. The *MHSA* has specific provisions for ensuring these individuals receive the treatment they need, while respecting their rights.

***MHSA* encourages voluntary receipt of services.**

1.14 *MHSA* Development

- First *Act* in 1879 was called *"The Dominion of Canada Act Respecting the Safeguarding of Dangerous Lunatics in the North-West Territories."*
- Seven significant changes including name changes occurred prior to 1986.
- 1986: *The Mental Health Services Act* enacted.
- 2015: Amendments to *The Mental Health Services Act* came into effect.

1.15 *MHSA* Structure including amendments

The *MHSA* has a number of parts which are reflected in the structure of the Guide. The amendments that came in to effect in 2015 which are presented in the next chapter have been incorporated into the *Act*.

Chapter 2

AMENDMENTS TO *THE MENTAL HEALTH SERVICES ACT*, effective 2015

2.1 Summary

Although the amendments which came into effect in 2015 are presented below in chronological order from *The Mental Health Services Act (MHSA)*, they can be thought of as addressing the following areas:

- Improved access to treatment: These sections of the *MHSA* were enhanced to ensure improved access to treatment:
  - Psychiatric residents under the supervision of a psychiatrist with admitting privileges to a mental health centre are now authorized to complete examinations for the compulsory admission to a mental health facility (Form G).
  - "Prescribed health professionals" (certain prescribed residents in psychiatry or nurses) can issue a Form A examination certificate if a physician is not available.
  - Police apprehensions are not restricted to disorderly conduct or to a public place.
  - The previous hospitalization criteria for Community Treatment Orders have been reduced and their allowable length has been extended to prevent chronic illnesses from developing.
  - Nurses have been given authority to prevent harm to a voluntary patient who wants to leave against medical advice.
- Regionalization of mental health services: Mental health services under the 1986 *MHSA* had their own administrative structure which pre-dates the regional health authority structure for the rest of health services. The 2015 amendments transferred most of these functions from the ministry to the regions including appointments (e.g. regional director, chief psychiatrist, etc.). A region cannot exclude people from service because they live outside the region. The approved home program has been transferred but with safeguards retained in the *MHSA*. Confidentiality and information issues, except in relation to mental health approved homes and providing personal health information to the review panel without consent, have now been removed from the *MHSA* and will now be governed by *The Health Information Protection Act*, which covers most health services. In addition to nearest relatives being informed of patient rights, if the person has a proxy or personal guardian that person must now also be informed.

- Modernization of language: Terms such as "psychiatric inpatient unit" have been replaced by the less stigmatizing term "mental health centre." "Him" has been replaced with "him or her."

2.2 The Amendments

This information is taken from Bill 127, an *Act* to amend *The Mental Health Services Act* and make a consequential amendment to *The Health Information Protection Act (HIPA)*.

The major changes or additions are presented in chronological order. These changes are discussed in more detail in the next chapters.

i. Interpretation (s. 2)

A number of definitions reflect a transfer of the minister's responsibilities to the regional health authorities. In addition, new terms include:

- (b) **business day** – a day other than a Saturday, Sunday or holiday.
- (c) **capacity** – as defined in *The Health Care Directives and Substitute Health Care Decision Makers Act*.
- (k) **mental health centre** – a facility designated under The Facility Designation Regulations under *The Regional Health Services Act* (term replaces "inpatient" facility).
- (q) **nurse** – registered nurse as defined in *The Registered Nurses Act, 1988* or a registered psychiatric nurse as defined in *The Registered Psychiatric Nurses Act*.
- (v) **personal guardian** and (y) **proxy**.
- Terms removed included "outpatient."

ii. Administration (s. 3 to 10)

- **Responsibilities of the minister (s. 3)** "The minister is responsible for the strategic direction of the system of mental health services in Saskatchewan and may do any things that the minister considers advisable to meet that responsibility." The minister no longer designates facilities (s. 4 repealed) under the *MHSA* but facilities are designated under The Facility Designation Regulations of *The Regional Health Services Act*.

iii. Regional Health Authorities (RHA) (s. 7 to 9)

- RHAs now appoint the regional director and a chief psychiatrist for their region. The regional director may appoint a "person responsible for the administration of this *Act* in the mental health centre" (officer-in-charge).

iv. Official representative (s. 10)

- The minister may appoint a "person," defined as including a partnership, as an official representative. Official representatives can be assigned to work in more than their own region.

v. Eligibility for services (s. 11 to 12)

- Regional health authorities or health care organizations shall "provide those services to each beneficiary on the same terms and conditions" and they may not include "any requirement with respect to place of residency of the beneficiary." (s. 11)

vi. Assessment, Admission, Treatment and Discharge (s. 17 to 31.1)

- **Involuntary examination ("prescribed health professional") (s. 18)**
  - If a physician is not available, a "prescribed health professional" may now complete and issue a certificate (Form A), which permits the person to be taken for an examination by a physician with admitting privileges to a mental health centre.
  - A prescribed health professional is one who meets the requirements of Regulation 11.1. Nurses and residents in psychiatry may be prescribed health professionals if they satisfy the minister as follows:

    "For the purposes of section 18 [Form A] and subsection 24.6(1) [CTO non-compliance] of the *Act*, the following are prescribed health professionals:

    (a) a resident in psychiatry under the supervision of a psychiatrist who has admitting privileges to a mental health centre;

    (b) a registered nurse [or psychiatric nurse] including a nurse practitioner who satisfies the minister that he or she:

    (i) is employed by a regional health authority;

    (ii) has at least five years' experience in the past 10 years working in the mental health field;

    (iii) is entitled to practise pursuant to *The Registered Nurses Act, 1988*; [or *The Registered Psychiatric Nurses Act, 1988*] and

    (iv) practises in a rural or remote area of Saskatchewan where access to physician services is limited."

However, the prescribed health professional can issue certificates:

"only if an attending physician is not available and the prescribed health professional has reason to believe that an attending physician will not become available within a reasonable period." (Regulation 11.1(2))

□ **Powers of peace officers (s. 20)**

- As previously, peace officers may apprehend and convey to a physician a person with a mental disorder, but the criteria have changed.
- The former requirements that the person be "in a public place" and the requirement that the person be "causing a disturbance by acting in a manner that would normally be considered disorderly" have been removed.
- The criterion is now that the peace officer has reasonable grounds to believe that the person is suffering from a mental disorder, and is "likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre." (s. 20(1)(b))

□ **Admission on medical certificates (s. 24)**

- "A resident in psychiatry under the supervision of a psychiatrist who has admitting privileges to a mental health centre" may now issue an admission certificate (Form G). (s. 24(1)(b))
- The second Form G certificate must not be issued by the psychiatrist supervising the resident at the time of issuance or another resident. (s. 24(4))

□ **Community treatment order (CTO) (s. 24.3 to 24.7)**

- The previous hospitalization requirement has been changed to "during the preceding two-year period, the person:

  a) has been admitted to a mental health centre, voluntarily or involuntarily, on at least one occasion; or

  b) has previously been the subject of a community treatment order." (s. 24.3(1)(ii))

  The previous requirement was three admissions or 60 inpatient days.

- If considered necessary, the treatment plan can state that the person is required to stay at a residence specified by the psychiatrist. (s. 24(3)(1)(d.1)) The residence must be at a specified address but can be changed by the psychiatrist without having to write a new CTO.
- Two psychiatrist's certificates are still required for the initial CTO, but renewals now require one. (s. 24.4(4))
- The CTO, which was formerly issued for a maximum of three months, can now be issued for a period of up to six months before it must be renewed. (s. 24.5(1))
- A prescribed health professional in the absence of the attending physician may issue an order for a person who does not comply with a CTO to be taken for a psychiatric examination. (s. 24.6(1))

- **Authority respecting diagnostic and treatment services (Voluntary patients) (s. 25.1)**
  - For voluntary patients who do not have the capacity to make their own health care decisions about diagnostic or treatment procedures, the person who may make these decisions, including decisions for children, is now a nearest relative (described in detail in section 25.1), a proxy appointed by the person, or a personal guardian appointed by the court, if applicable.
- **Temporary hold for voluntary patients (s. 30.1)**
  - Now "a nurse in a mental health centre may detain or cause to be detained and, if necessary, restrain or cause to be restrained a voluntary patient requesting to be discharged if the nurse believes on reasonable grounds that the patient:
    a) has a mental disorder;
    b) because of the mental disorder, is likely to cause serious harm to himself or herself or to another person or to suffer serious mental or physical deterioration if the patient leaves the mental health centre; and
    c) needs to be examined by a physician or resident in psychiatry."
  - The patient "must be examined by a physician or a resident in psychiatry within three hours after the detention commenced."

vii. ECT (Electroconvulsive therapy) (Regulation change 14(5))

- Regulation 14(5) has been amended by striking out eight and substituting 12 for the number of treatments a certified patient can receive before the psychiatrist must repeat the initial requirements of administering ECT found in Regulations 14 (1-4), including informing the patient of the risks and benefits of ECT and notifying the official representative and being given the right to appeal.

viii. General issues

- **Mental health approved homes (s. 37 to 37.94)**
  The authority to grant licenses and the general management of approved homes has been transferred from the ministry to the regional health authorities. However, appeals against regional health authority decisions (e.g. cancel a license) will be handled by the ministry.
- **Confidentiality and release of information s. 38**
  Section 38 has been deleted, removing confidential and release of information clauses from the *MHSA*. All confidentiality and release of information issues, except for those relating to mental health approved homes and providing personal health information to the review panel without consent, are now governed by *The Health Information Protection Act (HIPA)* as the exemption for the *MHSA* in *HIPA* clause 4(4)(e) will be repealed.

Chapter 3

DESIGNATIONS, DEFINITIONS AND ADMINISTRATION (Section 2 to 10)

The Mental Health Services Act (MHSA) only allows involuntary patients to be admitted to designated inpatient units, now called "mental health centres." It also defines a number of terms used throughout the *MHSA* and addresses the administration of services under the *MHSA*. This chapter addresses these issues.

3.1 Designated mental health centres

An involuntary patient can only be admitted to a designated mental health centre.

A physician or prescribed health professional can conduct an examination anywhere to see if a person needs an involuntary examination. This could be in an emergency room, private office or clinic or at a person's residence. However, an involuntary patient can only be admitted, detained and treated in a specially designated mental health centre, usually in a general hospital, unless otherwise directed by the provincial director of mental health services. The minister makes the designation under The Facility Designation Regulations made pursuant to *The Regional Health Services Act*. The list of designated mental health centres is in **Appendix 3**.

A person can voluntarily request to be admitted to a designated mental health centre with the advice and on the arrangements of a physician with admitting privileges to a mental health centre. They may also be admitted to other beds in any hospital when not admitted to a designated mental health centre by their physician with hospital admitting privileges.

3.2 Definitions

The *MHSA* defines or interprets over 30 terms that are used in the *Act*. Examples include: mental disorder, mental health centre (formerly referred to as an inpatient unit), and many more (see Interpretation, s. 2). These terms are explained when they arise in the Guide.

3.3 Administration

The 2015 amendments to the *MHSA* transferred a number of responsibilities from the minister and the Ministry of Health to the regional health authorities (see Chapter 2 on amendments). The following are the current responsibilities for administering the mental health system. For more detail see the *Act* and Regulations.

- **Minister (s. 3)**
  The minister is responsible for the strategic direction of the system of mental health services and may do anything the minister considers advisable to meet that responsibility. Examples of this are provided in s. 3.
- **Provincial director of mental health services (s. 6)**
  The minister may appoint and direct an employee of the Ministry of Health as director of mental health services.
- **Regional [mental health] directors (s. 7)**
  The regional health authority appoints a regional director who is responsible for the provision of mental health services in the region.
- **Officer in charge (s. 8)**
  The regional director may designate a person to be the officer in charge of the administration of a mental health centre and where this does not occur the regional director is the officer in charge.
- **Chief psychiatrist (s. 9)**
  The regional health authority designates a chief psychiatrist for that region.
- **Official representative (s. 10)**
  The minister appoints the official representatives. Often the official representative is a lawyer or law firm, but this is not required to be so. The official representative assists patients in understanding and exercising their rights and obligations (e.g. review panels).

Chapter 4

ELIGIBILITY FOR SERVICES AND GENERAL RIGHTS AND OBLIGATIONS (Section 11 to 16)

The Mental Health Services Act (MHSA) sets out the requirements for a person to receive free mental health services in Saskatchewan. Given that certain rights are restricted with involuntary admission, in order to gain other rights such as the right to receive treatment and be well, the *MHSA* addresses general rights and obligations and provides for more specific rights such as the right to be informed and the right to appeal to the review panel and to receive assistance from the official representative. These rights will be explored later. (See **Appendix 1: Personal Rights and *The Mental Health Services Act***)

4.1 Eligibility for services (s. 11 and 12)

Any person covered under *The Saskatchewan Medical Care Insurance Act* is eligible for free mental health services provided by regional health authorities and licenced medical practitioners. For people who are not covered, the minister may enter into any agreement with the person to provide services. This would ordinarily be done through the reciprocal billing agreements with other provinces and territories.

4.2 General rights and obligations

- **Preservation of rights (s. 14)**
  Section 14 states that "no person is to be deprived of any right or privilege enjoyed by other persons solely because he or she (a) is receiving or has received mental health services" or has been named in any document associated with the *MHSA*.
- **Restrictions as to persons giving certificates (s. 15)**
  Where two certificates are required, the physicians cannot be related to either each other or the patient by blood or marriage.
- **Right to be informed (s. 16)**
  s.16(1) "Every person who is apprehended or detained pursuant to section 18, 19, 20, 21, 22, 23, 24, 24.1 or 24.3:
  - (a) must be informed promptly of the reasons for his or her apprehension or detention, as the case may be; and
  - (b) is entitled on his or her own request to receive a copy of the certificate, warrant or order pursuant to which he or she has been apprehended or is detained, as the case may be, as soon as is reasonably practicable.

(2) Where a person is apprehended or detained pursuant to section 18, 19, 21, 22, 23, 24, 24.1 or 24.3 or is transferred pursuant to section 28, an official representative for the region shall be provided with a copy of the certificate, warrant or order pursuant to which the person is or was apprehended, detained or transferred, as the case may be, as soon as is reasonably practicable."

Chapter 5

ASSESSMENT, ADMISSION, TREATMENT AND DISCHARGE (Section 17 to 31)

5.1 Introduction

This chapter covers Part V of *The Mental Health Services Act (MHSA)* as amended and includes sections 17 through 31 with their Regulations. The chapter includes:

- voluntary services (s. 17)
- temporary hold by a nurse for voluntary patients (s. 30.1) (New 2015)
- assessments leading to a psychiatric examination through a physician, peace officer or judge (s. 18 to 20)
- involuntary assessment for admission: process (s. 24)
- involuntary assessment for admission: criteria (s. 24)
- other admissions
    - medically related – alternatives to the *MHSA*
    - from or to another province (s. 21) (s. 28.2)
    - court and forensic (s. 22 to 23.1)
- renewal examinations (s. 24(7) and (8))
- long term detention orders (s. 24.1)
- community treatment orders (s. 24.2 to 24.6)
- treatment: duty to provide, authority to order (s. 24.7 to 25.1)
- temporary removal and return from the mental health centre (s. 29)
- transfers to another facility (s. 28)
- unauthorized leave from the mental health centre (s. 30)
- discharge (s. 31) and notices to patient (s. 31.1)

A number of appendices provide more detail on these issues.

5.2 Voluntary services: Mental health centre admission and treatment

Section 17 addresses voluntary services. Subject to the regulations and availability of services a person may voluntarily receive assessment and treatment services including admission.

A person can voluntarily request to be admitted to a mental health centre under the *MHSA*:

> "a person may, on his or her own request: (a) receive assessment and treatment services; (b) with the advice and on the arrangements of a physician with admitting privileges to a mental health centre, be admitted to a mental health centre; or (c) receive other service available pursuant to this *Act*." (s. 17)

The admission may be requested by a parent or guardian of a child, or by a mature minor – someone able to make this health care decision.

The criteria for being voluntarily admitted to a mental health centre are less stringent than for an involuntary admission. The only criteria are that the person requires care that can be provided in a mental health centre, and that the person consents to the admission. The person does not have to meet the "mental disorder" definition of the *MHSA*.

If a person is voluntarily admitted to a mental health centre under the *MHSA*, the person needs to be in a designated mental health centre bed.

If a person is voluntarily admitted to a mental health centre under the *MHSA*, the person can now be held for up to three hours for a psychiatric examination if the nurse on the designated unit believes that the person meets the involuntary admission criterion. (s. 30.1) (See **Appendix 11 Nurse Responsibilities**)

For children up to 18 years of age, a parent or guardian can voluntarily admit the child to a mental health centre in order to receive *MHSA* services with agreement of a physician with admitting privileges to a mental health centre. However, if the child is a mature minor, the child may have the same health decision-making rights as an adult.

The *MHSA* does not prohibit an adult who lacks the capacity to make a voluntary admission decision to be admitted by a substitute decision maker under *The Health Care Directives and Substitute Health Care Decision Makers Act*. If there is no proxy or personal guardian, the nearest relative may make the decision for the person.

Treatment of a voluntary patient must be consented to by the patient. However, if the patient is not competent to consent, the nearest relative, proxy (person previously appointed by the patient to make treatment decisions) or personal guardian (appointed by the court) if any, may make the decision. (s. 25.1)

A voluntary patient may also be admitted to other beds in any hospital when not admitted to a mental health centre, by their physician with hospital admitting privileges. However the nurse hold authority (s. 30.1) only applies to a nurse in a mental health centre.

Appendix 4: Voluntary and "Alternate" Admission Procedures provides more detail on the admission process for persons voluntarily requesting to be admitted to a mental health centre. It also addresses alternate routes of admission to address requests for involuntary admission, which are not appropriate under the *MHSA*. These requests might include admission to address physical health issues of a person not capable of making a treatment decision, or intoxication where a psychiatric examination cannot be completed. *The Health Care Directives and Substitute Health Care Decision Makers Act*, for example, may be more appropriate in these circumstances.

5.3 Involuntary Admission

Methods for accessing involuntary examination and admission

Where a person needs hospitalization for a mental disorder but it is not possible for them to be admitted voluntarily, access to admission may still be possible through the *MHSA* involuntary admission provisions if the person meets certain criteria. There are three methods of initiating a psychiatric examination which may lead to involuntary hospitalization: by way of a physician or prescribed health professional, a peace officer, or a Provincial Court Judge. Determining which method is appropriate depends on the situation (urgency, availability of assistance, etc.). It is usually preferable to use the physician or prescribed health professional first. If that is not possible in the circumstances, a peace officer or a Provincial Court Judge may be utilized.

1. A physician or prescribed health professional (Form A) (s. 18) (New 2015)

A person may be examined at their residence, a doctor's office or, more usually, at a hospital emergency room. The examination may be conducted by any licensed physician or a prescribed health professional if a physician is not available and will not become available within a reasonable period. A prescribed health professional is either a resident in psychiatry or a nurse who qualifies under the *MHSA* Regulation 11.1 (see Chapter 2). The examination may include information from the direct examination of the person and from information the examiner receives from other sources.

Criteria for Form A:

The person:

> "(a) …is suffering from a mental disorder and requires a psychiatric examination to ascertain whether he or she should be admitted to a mental health centre pursuant to section 24; and (b) refuses to submit to the examination mentioned in clause (a)" s. 18(1)

The reference in the criterion that the person "refuses to submit to the examination" is not that the person is refusing to participate in the current examination, but is refusing to submit to a psychiatric examination by a physician, usually a psychiatrist, with admitting privileges to a mental health centre. If the person meets this criterion, a "Certificate of Physician or Prescribed Health Professional that a Psychiatric Examination is Required" (Form A) is completed.

To meet the Form A criterion it must be stated that:

> "…the examining physician or prescribed health professional has personally examined the person who is the subject of the certificate and, after due inquiry into the necessary facts relating to the case of the person, has formed the opinion [that the criterion is met]." (s.18(4)(a))

"Due inquiry" means that the examiner may consider information not directly from the person such as information from relatives or others, from records.

Timelines for completing and conveying on Form A:

> "No person shall be conveyed for a psychiatric examination more than seven days after the date on which the examination for the purposes of subsection (1) [psychiatric examination by a physician with admitting privileges] was made." (s. 18(5))

This means that if a Form A were filled out five days after the initial examination, without completing any further examinations then there are only two days left to apprehend and convey the person. The maximum seven day period for the person to be conveyed for a psychiatric examination by a physician with mental health centre admitting privileges starts from the date of the initial examination, not from when the Form A was completed.

Assuming the criteria for Form A are met, after arrangements with a physician who has admitting privileges to the mental health centre have been made, the person can be taken to a physician at the mental health centre for a psychiatric examination. The Form A is valid for seven days after the date of the examination. This can be useful in the event that there is a delay in the conveyance to a mental health centre, for example, if the person under examination left and could not be found right away in order to be conveyed to a place where a psychiatric examination will be completed.

Once the person arrives at the mental health centre, the examination should be completed as soon as possible, and must be completed within 24 hours. The apprehension and conveyance to the mental health centre can be done by anyone, but it is frequently done by a peace officer. (See **Appendix 5: Completing Form A: Certificate of Physician or Prescribed Health Professional that Psychiatric Examination is Required**)

2. A peace officer (s. 20)

A peace officer (officer) acting on the authority of the *MHSA*, who has reasonable grounds, may take the person to any physician for an examination to determine if they need a psychiatric examination.

The criteria the officer uses have changed (New 2015). The person no longer has to be "in a public place" nor "causing a disturbance in a manner that would normally be considered disorderly." The criteria now are:

> s. 20(1) "A peace officer may apprehend a person without a warrant and convey that person as soon as is reasonably practicable to a place where he or she may be examined by a physician if the peace officer has reasonable grounds to believe that the person is:
>
> (a) suffering from a mental disorder; and
>
> (b) likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre.
>
> (2) A person apprehended pursuant to subsection (1) must be examined by a physician as soon as is reasonably practicable and in all cases within 24 hours after his or her apprehension."

Officers usually take the person to the emergency room of a hospital with a designated mental health centre for this examination.

If the person is examined by a physician without admitting privileges to the mental health centre (most emergency room physicians) a Form A may be issued. Form A allows detention for up to 24 hours. If, however, the person is seen by a physician with admitting privileges to the mental health centre, Form A is not required and the first Form G can be issued. (See **Appendix 7: Peace Officer Responsibilities**)

3. A Provincial Court judge (s. 19)

Where it is not possible under the circumstances for the person to have a voluntary examination by a physician or prescribed health professional, or for a peace officer to become involved, a Provincial Court judge may be asked to issue a warrant providing authority to a specified person, usually a peace officer, to apprehend and convey the person to a mental health centre for a psychiatric examination.

The criteria used by the person who goes to the court to lay information that the individual is in need of a psychiatric examination are:

> "A person may lay an information before a judge of the Provincial Court of Saskatchewan in the prescribed form and manner if that person believes on reasonable grounds that another person who refuses to submit to a medical examination:
>
> (a) is suffering from a mental disorder; and

(b) is in need of examination to determine whether he or she should be admitted to a mental health centre pursuant to section 24." (s. 19)

The judge makes the decision on the basis of sworn evidence (Form B) often from a family member. "Refuses to submit to a medical examination" means the examination of a physician or prescribed health professional (Form A). After making arrangements with a physician with admitting privileges the judge issues a warrant (Form C) for any peace officer or a named person to take the person to the place where the person is to be examined by a physician with admitting privileges or a psychiatric resident. (See **Appendix 2: Family and Friends Involvement**)

5.4 Admission on medical certificates (Form G) (s. 24)

Completion of a Form A, peace officer apprehension, or a warrant do not "guarantee" admission.

Two Form Gs are required before a person is fully involuntarily admitted to a mental health centre. It is important to note that just because a Form A has been completed, a warrant has been issued by a judge or an apprehension has been made by a peace officer, this does not mean that the person will necessarily be admitted to a mental health centre. The psychiatric examination that will be completed for the purposes of the Form Gs is more involved than the examination for the purposes of a Form A as there are more requirements needing to be met for a Form G than for a Form A. For example, the requirement on the Form G that the person "is unable to fully understand and make informed decisions regarding his or her need for treatment or care and supervision" is not required for a Form A, a peace officer apprehension, or a judge-issued warrant for apprehension.

Pathways to a Form G examination:

The person can access the first Form G examination in four ways:

1. Form A issued by a physician without admitting privileges to the mental health centre or a prescribed health professional. Often this is by a physician at an emergency department. The first Form G is then required.

2. At the hospital or elsewhere by being examined directly for Form G by a physician with admitting privileges to the mental health centre.

3. Where the person was apprehended by a peace officer (s. 20) and taken to a physician without admitting privileges if that physician (not a prescribed health professional) issues a Form A. After arrangements are made by the physician, the officer conveys the person to a place where he or she may be examined for Form G purposes.

4. On a warrant issued by a judge to be taken to a place where he or she may be examined for Form G.

Who may complete Form Gs? (New 2015)

- "On the issuance of the certificates [Form Gs] of two physicians at least one whom is a psychiatrist" (s. 24(3)) a person can be admitted involuntarily.
- Both physicians, including the psychiatrist, must have admitting privileges to the mental health centre, except a resident who must be under the supervision of a psychiatrist with admitting privileges to the mental health centre.
- (New 2015) Now a "resident in psychiatry under the supervision of a psychiatrist who has admitting privileges to a mental health centre" can also complete a Form G. (s. 24 (1(b)). However, if a resident issues a Form G the second Form G must not be issued by another resident or by the resident's supervisor. (s. 24(4))
- "…if it is not reasonably practicable to obtain the certificates of two physicians at least one whom is a psychiatrist, on the issuance of the certificate of one physician" the person can be admitted and detained there until the end of the third day following the day on which he or she is admitted. If an inpatient already, the person can be detained until the end of the third day following the date of the issuance of the certificate. The second opinion is to be obtained as soon as practicable. (s. 24(5)(6))

Timelines for Form Gs

- The time between the examination for Form G and completing the Form G certificate must not be longer than 72 hours. Any Form G certificate must "state that the physician has examined the person named in the certificate within the preceding 72 hours." (s. 24(2))
- For a person who is not an inpatient, the maximum time between the date of the first examination for Form G and the admission to a mental health centre is seven days. (s. 24(9))
- For a person who is not an inpatient when one Form G is completed the "person may be apprehended, conveyed and admitted to a mental health centre and detained there until the end of the third day following the day on which he or she is admitted." (s. 24(5)(a))
- If the person is an inpatient (by virtue of Form A for up to 24 hours, or a voluntary patient) the first Form G authorized detention "until the end of the third day following the date of the issuance of the certificate." (s. 24(5)(b))
- For a person who is not an inpatient but has had two Form Gs completed, the person "may be apprehended, conveyed and admitted to a mental health centre and detained there until the end of the 21st day following the day that he or she is admitted." (s. 24(3)(a)) For a person who is already an inpatient the two Form Gs authorize detention "until the end of the 21st day following the date of issuance of the first of the certificates." (24(3)(b)) Thus if, while in the hospital, the first certificate was written on the 1st day of the month, on the 22nd day of the month both certificates would lapse unless renewed. (See **Appendix 6: Completing Form G: Certificate of Medical Practitioners for Compulsory Admission of a Person to a Mental Health Centre**)

Criteria for Form G

The requirements and criteria for issuing a "Certificate of Medical Practitioners for Compulsory Admission of a Person to a Mental Health Centre" (Form G) and for renewal certificates are in section 24. All criteria must be met.

s. 24(2) "Every certificate issued for the purposes of this section is to be in the prescribed form [Form G] and is to:

(a) state that the physician has examined the person named in the certificate within the immediately preceding 72 hours and that, on the basis of the examination and any other pertinent facts regarding the person or the person's condition that have been communicated to the physician, he or she has reasonable grounds to believe that:
  (i) the person is suffering from a mental disorder as a result of which he or she is in need of treatment or care and supervision which can be provided only in a mental health centre;
  (ii) as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his or her need for treatment or care and supervision; and
  (iii) as a result of the mental disorder, the person is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre."

When the person is detained, and that could be on the issuance of one Form G, the person, nearest relative and proxy or personal guardian, if any, and the official representative must be informed of the patient's admission and rights. The person is visited by the official representative who explains the person's rights and obligations. The person becomes eligible to appeal to the review panel for release. (See **Appendix 9: Review Panel and Official Representative Procedures**)

Appendix 6: Completing Form G: Certificate of Medical Practitioners for Compulsory Admission of a Person to a Mental Health Centre addresses a number of issues about these criteria such as what constitutes an examination, how harm and deterioration are assessed and others.

5.5 Renewal certificates (s. 24(8))

In order to renew a patient's involuntary hospitalization under section 24 of the *MHSA*, prior to the end of the 21st day following the date upon which the first Form G was issued, new Form G certificates much be issued by two physicians at least one of whom is a psychiatrist. A resident may complete one renewal certificate since a resident is defined as a physician in section 24 of the *MHSA*. Successive 21 day periods can follow. It is always the patient's right to appeal. However, mandatory appeals are done at the end of the first 21 days, and every six months. (s. 34(5)) (See **Appendix 9: Review Panel and Official Representative Procedures**)

5.6 Long term detention orders (s. 24.1)

A relatively small number of people need very long periods in hospital. While multiple 21 day periods can continue indefinitely, Long Term Detention Orders, granted by a court, are designed to assist people who have had a total of 60 days or longer in a mental health centre and their severe disabling continuing mental disorder is likely to persist for a period longer than 21 days. (s. 24.1(1))

The difference in criteria for the Long Term Detention Order and the Form G is that in the long term detention order the person must be "likely to cause bodily harm to himself or herself, or to others." The broad harm criteria of s. 24 have been narrowed to bodily harm. The deterioration alternative has been eliminated.

When an application to the Court of Queen's Bench is made by the officer in charge of the mental health centre where the patient is, the patient, nearest relative and any proxy or personal guardian and the official representative must be notified. A lawyer is usually involved in this court process. After a hearing, the judge decides if the criteria have been met. The judge can issue an order for detention of the person for a period of up to one year for the purposes of treatment, care and supervision. For renewals, the same process would have to be repeated. Detention orders can be reviewed on request by the court. People on these orders are usually treated at the Saskatchewan Hospital North Battleford.

5.7 Other admissions

The first type of admission to hospital discussed here is not directly addressed in the *MHSA* but is presented here because there may be more appropriate methods, from the patient's and a legal point of view, for some patients to receive non-voluntary services through laws other than the *MHSA*. These are called "Alternatives to the *MHSA*." The other two types of admission discussed here are addressed in the *MHSA* and involve persons admitted from or going to other provinces and persons involved with the Criminal Code admitted through the courts.

- **Alternatives to admissions under *The Mental Health Services Act***
  Sometimes psychiatrists are asked to certify a person, usually on a medical ward, who is incapable of making a treatment decision and who is resisting treatment. The rationale is that the person can then be required to take the treatment. However, the *MHSA* can only provide, without consent, treatment for persons suffering from mental disorders. *The Health Care and Substitute Health Care Decision Makers Act* provides for this situation. This *Act* can also be more appropriately used than the *MHSA* where a person is admitted as intoxicated and it is not possible to complete a psychiatric examination to determine if the person has a mental disorder. *The Health Care and Substitute Health Care Decision Makers Act* allows under certain circumstances, the person to be held, assessed and treated. If psychiatric consultation is found to be

required, the voluntary or involuntary provisions of the *MHSA* may then apply. (See **Appendix 4: Voluntary and "Alternative" Admission Procedures**)

- **Patients brought into or sent from Saskatchewan (s. 21, s. 28.2)**
  Section 21 provides authority for the provincial director of mental health to order that a person detained in a hospital outside Saskatchewan be conveyed to a mental health centre and examined within 24 hours by a physician who has admitting privileges. Form D is used for this.

  Section 28.2 authorizes the provincial director to return an involuntary patient to another jurisdiction if an order for a compulsory psychiatric examination has been issued from the other jurisdiction (Form L.2). A copy of the order must be given to the official representative and the order may be appealed by the patient or official representative to the Court of Queen's Bench.

- **Examination, admission and treatment of person charged with an offence (s. 22)**
  A person charged with an offence in custody can voluntarily request an examination to determine if he or she should be treated for a mental disorder and a judge can, after making arrangements with a psychiatrist or other professional, order the person to the place where the examination will take place. (s. 22(2)) A judge who considers a person charged with an offence to be suffering from a mental disorder and is in need of an examination can, after making arrangements, order the person to be examined as an outpatient. A peace officer must accompany the person for the examinations. A person can be admitted as a voluntary patient or involuntary patient for treatment if the person meets the appropriate criteria and the court approves.
- **Admission and examination under a warrant (s. 23 and 23.1)**
  A person with a mental disorder found not fit to stand trial or not criminally responsible on account of a mental disorder or who has been transferred from a penitentiary may be admitted and detained in a mental health centre. Where the detention under the Criminal Code of a person found unfit to stand trial or not criminally responsible on account of a mental disorder is about to expire, the provincial director may order that the person be examined to determine if he or she meets the involuntary admission requirements of the *MHSA*.

5.8 Community Treatment Orders (s. 24.2 to 24.7)

Community Treatment Orders (CTO) are designed to assist a patient with a severe mental disorder who will not voluntarily accept community treatment with the necessary motivation and supports to adhere to a community treatment plan to prevent relapse and rehospitalization. To qualify for a CTO the person must, within the previous two year period, have had one mental health centre admission, either voluntary or involuntary, or have had a previous CTO. In addition, it must be found that:

> "…if the person does not receive treatment or care and supervision while residing in the community, the person is likely to cause harm to himself or herself or to others, or

> to suffer substantial mental or physical deterioration, as a result of the mental disorder." (s. 24.3(1))

Also, the services required by the CTO must be available and the patient must be able to use them.

One psychiatrist must complete Form H.3 "Community Treatment Order" and a second psychiatrist must examine the person and complete Form H.4 "Certificate in Support of a Community Treatment Order," using the same criteria. The CTO can last up to six months and be renewed by one psychiatrist if there has been no lapse in the CTO.

When a person is placed on a CTO, notices are sent to the patient, the patient's nearest relative, and others including the official representative who visits the patient. The patient or others can appeal to the review panel voluntarily, and every six months there is an automatic review by the review panel unless an appeal has occurred in the preceding 21 days. (s. 34(5.2)) (See **Appendix 9: Review Panel and Official Representative Procedures**)

If a person on a CTO does not adhere to the plan, the attending physician (or in the absence of the attending physician, a prescribed health professional) can issue an order for the person to be brought by a peace officer for an examination. If a patient leaves the province the CTO has no effect in another jurisdiction. If the person returned to Saskatchewan during the period the CTO was written for, it would then be valid. If the person became involved with the mental health system in another jurisdiction the "Patients Brought Into or Sent From Saskatchewan (s. 21, s. 28.2)" sections discussed above may apply.
(See **Appendix 8: Community Treatment Orders**)

5.9 Temporary removal and return (s. 29)

The *MHSA* provides for involuntary patients (including those held under a Long Term Detention Order) to temporarily leave the mental health centre to receive health care or for activities that "will be of benefit to the patient." A time limit is not placed on this temporary authorized leave. The section reads:

> s. 29(1) "Subject to the Regulations, the attending physician may authorize the temporary removal of an involuntary patient from a mental health centre to an appropriate place, having ascertained that the patient:
>
> (a) requires health care or other services that cannot be provided in the mental health centre; or
> (b) requires a temporary absence from the mental health centre for activities that will be of benefit to the patient.
>
> (2) From the time of the involuntary patient's removal pursuant to subsection (1) until his or her return to the mental health centre, the patient is deemed to continue to be a

patient of the mental health centre in the same manner and to the same extent and is subject to the same control as if he or she were in the mental health centre."

(a) for health care

This may be for medical, surgical or even mental health care that cannot be provided in the mental health centre. If the care is in a hospital out of the region a transfer must be arranged (see next section on Transfers). Because the same authority for control exists as if the person was in the mental health centre, staff in the other health service can restrain or restrict the person as if they were in the mental health centre.

(b) for "activities that will benefit the patient"

"Benefit the patient" is a broad term that is not restricted by the *MHSA*. The benefit could presumably be in assisting in rehabilitation by going to programs off the inpatient unit, recreational/health services such as: attending gyms, jogging off the mental health centre grounds, or keeping relationships such as contact with family, going for a Sunday drive or to church or for a week at the summer cottage, or for pleasure by attending normalizing activities such as sporting events and movies.

Permission must be given by the attending physician for an activity that will benefit the patient. The physician is required to be as sure as is reasonable that the person will not cause harm to themselves or others. This will determine the type of supervision needed. Whether the person can go by themselves unescorted or need someone with them or need staff with them or not go at all, is a judgement call made by the attending physician.

The attending physician may place restrictions on the activities because the patient is "subject to the same control as if he or she were in the mental health centre" (s. 29); for example, curfews and orders not to drink or consort with certain people. The physician can inform people who are with the patient that they can forbid the patient from doing certain things and restrain if necessary. If the person contravenes these instructions the person responsible can contact the attending physician who may ask the police to apprehend and return the person to the mental health centre because the person, having contravened the restrictions of the absence, is on an unauthorized absence.

There is no regulated Form for granting temporary absence for activities that will benefit the patient. It is suggested that the attending physician make a note on the file outlining the purpose of the absence, who has supervisory responsibilities, the length of time, any restrictions (e.g. alcohol, visiting certain people), and contact information including emergency phone numbers. The person and anyone responsible during the absence should be informed of this information. Providing written material to people involved may be helpful.

Liability for involuntary patients on temporary absence

The *MHSA* allows involuntary patients to be absent from the facility for "activities that will benefit the patient." The use of a temporary absence is therefore clearly within the law

which considerably reduces liability compared with the *MHSA* being silent on the issue and a patient being given a pass. In fact that is why the provision is there, for the benefit of the patient and the protection of liability, for the staff who act in good faith.

With reasonable selection, and plans and instructions for those involved, it is unlikely that things will go wrong. If there is an incident, anyone can sue anyone but staff who have acted in good faith are protected by the limitation of liability provision in s. 39 (see section on Liability).

5.10 Unauthorized absence (s. 30)

An involuntary patient who leaves the mental health centre without permission is on "unauthorized absence" and may be brought back to the centre. The *MHSA* states:

> s.30(1) "If a patient who is detained pursuant to section 24 leaves a mental health centre without having been discharged, the attending physician may, within 21 days after the patient's departure, if he or she considers it advisable to do so, order that the patient be returned to the mental health centre.
>
> s.30(2) If the attending physician orders that a patient be returned to a mental health centre pursuant to subsection (1), the patient may be apprehended and returned to the mental health centre, without a warrant, by:
> (a) any peace officer; or
> (b) any person designated by the attending physician.
>
> s.30(3) If a patient who is detained pursuant to section 24 leaves a mental health centre without having been discharged and remains absent from the mental health centre for a period of more than 21 days, he or she is deemed to be discharged from the mental health centre."

5.11 Treatment consent or authorization (s. 25)

Voluntary patient

> s.25(1) "Except in a case of emergency, if a patient is in a mental health centre pursuant to section 17, [voluntary patient] no diagnostic or treatment services or procedures are to be carried out on the patient except with his or her consent or, where he or she does not have the capacity to consent, with the consent of his or her nearest relative, or proxy or personal guardian, if any."

The voluntary patient can accept or refuse any treatment offered by the physician. If the person is not competent to make the treatment decision then consent can be given by the person's nearest relative or a proxy (a person named in a health care directive) or a personal guardian (approved by the court). The first person in a list of relatives or others (s. 25.1) willing and available to make the decision may make it.

Involuntary patient

Authorization without consent

> s. 25(2) "Subject to the regulations and to subsections (3) to (5), the attending physician may perform or prescribe any diagnostic procedures he or she considers necessary to determine the existence or nature of a mental disorder and administer or prescribe any medication or other treatment that is consistent with good medical practice and that he or she considers necessary to treat the mental disorder to a patient who is detained pursuant to section 24 or 24.1 without that patient's consent."

Patient's involvement and views are important

> s. 25(3) "In the course of on-going diagnosis or treatment, to the extent that it is feasible given the patient's medical condition, the attending physician shall consult with the patient, explain or cause to be explained to the patient the purpose, nature and effect of proposed diagnosis or treatment and give consideration to the views the patient expresses concerning the patient's choice of therapists, the proposed diagnosis or treatment and any alternatives and the manner in which diagnoses or treatments may be provided."

Duty to provide care and treatment

While the attending physician makes the decision to treat after due consideration of the patient's views and good medical practice, there is an obligation on the physician to help the person to get well enough to be discharged from being an involuntary patient. The section reads:

> s. 27 "Subject to section 25, if a person is detained in a mental health centre, the attending physician shall endeavour with all resources reasonably available in the mental health centre to provide the person with care and treatment with a view to the result that the detention of the person in the mental health centre will no longer be required."

Comment on treatment authorization without consent

The *MHSA* requires the attending physician to make the treatment decision, after due consideration of the patient's views and in accord with good medical practice. This is different from the consent decisions under *The Health Care Directives and Substitute Health Care Decision Makers Act*, where the person, if capable, makes the decision and if not capable, a substituted decision maker decides.

There are two reasons for the *MHSA* requiring the attending physician to make the treatment decision. First, the involuntary patient cannot make the decision, because by definition he or she is not capable of making a "… decision regarding his or her need for treatment." Incapability is an involuntary admission criterion. (s. 24(2)(a)((ii)) Therefore

someone else must make the decision. Second, if a person through an advance health care directive or a substitute decision maker refuses treatment, the person would continue to be detained until they got better on their own (which is unlikely without treatment) or would continue to suffer and, untreated, would be more likely to harm fellow patients or staff. As the Saskatchewan Law ReForm Commission stated:

> "Civil commitment exists to provide treatment for seriously disturbed patients. If treatment cannot be provided by the facility to which the patient has been committed, there is no jurisdiction for continuing the committal. Logically, therefore, authority to direct hospitalization without consent of the patient must entail authority of some form of treatment without consent."
>
> - Saskatchewan Law Reform Commission, Proposals for a Compulsory Mental Health Care Act: (1985) pg. 26

What if the person has an advance health care directive?

An advance health care directive for an involuntary patient "relating to treatment of mental disorder," in hospital or in the community, is not binding under the *MHSA* as s. 5 of *The Health Care Directives and Substitute Health Care Decision Makers Act* shows:

> s. 5(4) "Where a directive is made by a person who is the subject of a certificate pursuant to section 24 of *The Mental Health Services Act*, a detention order pursuant to section 24.1 of that *Act* or a community treatment order pursuant to section 24.2 of that *Act*:
>
> (a) a health care decision in the directive relating to treatment for a mental disorder is to be <u>used for guidance</u> as to the wishes of the person making the directive;
> (b) subsections (1) and (2) apply with respect to any other health care decisions in the directive;
> (c) a health care decision made by a proxy relating to treatment for a mental disorder is to be used for guidance as to the wishes of the person making the directive; and
> (d) subsection (3) applies with respect to any other health care decisions made by a proxy."

The reason an advance health care directive must be taken into account but is not binding is that the person is in detention and the attending physician has an obligation to provide all necessary means for ending the detention (see s. 27). If an advance health care directive had to be followed that refused all treatment or directed only ineffective or dangerous treatments, it would thwart the intent of the *Act* and place the physician in an untenable moral dilemma.

Consent to non-mental health treatment

Mental health treatment for an involuntary patient is authorized by the attending physician under the *MHSA*. However, non-mental health treatment cannot be authorized under the *MHSA*. Consent for an involuntary patient's admission or treatment for a surgical, medical, orthopedic or any other non-mental health problem must be consented to in accord with *The Health Care Directives and Substitute Health Care Decision Makers Act* if the person is incapable of making a health care decision. An advance health care directive is binding on the provider for non-mental health decisions. The *MHSA* cannot be used to certify someone because they are incapable and resisting care for the purposes of providing medical treatment. (See **Appendix 4: Voluntary and "Alternative" Admission Procedures**)

Special treatments

Some treatments may only be provided to involuntary patients without their consent if the treatment class has been designated by the minister. (s. 25(4)) These treatments fall outside the range of treatments that the attending physician may authorize. A special procedure is set up in the regulations to address the designated treatment. Electroconvulsive therapy (ECT) is the only treatment currently designated.

ECT – Regulation 14

ECT may be given to an involuntary patient under the *MHSA* if the following procedure is followed:

A psychiatrist must:

- give the ECT or have it given by a physician under the direct supervision of a psychiatrist;
- examine the patient and conclude ECT will help the person and without it they will not improve and that alternate treatments are likely ineffective;
- complete a report;
- ensure pre-ECT measures are up to standard;
- explain all aspects of ECT and preliminary and post ECT issues;
- consider the view of the nearest relative or other decision makers about ECT and alternate treatment and inform the nearest relative and any other decision makers; and
- complete a certificate (Form I).

A second psychiatrist must conduct an independent examination and complete a certificate (Form I). The involved relatives/decision makers must be informed as well as the official representative (Form J). The decision to give ECT may be appealed to the review panel (Form N).

The maximum number of treatments in a course is now 12 (New 2015– previously eight). For more than 12 treatments in a therapeutic series, the authorization process must be repeated. See Regulation 14 of the *MHSA* for the exact procedures.

If ECT is to be given to a voluntary patient *The Health Care Directives and Substitute Health Care Decision Makers Act* applies. None of these *MHSA* procedures are required. The capable person or a substitute decision maker can consent to ECT.

Treatments only with informed consent

> s. 25(5) "In no case shall a physician or any other person administer psychosurgery or experimental treatment to an involuntary patient."

In the unlikely event that psychosurgery were recommended (it was last used in Saskatchewan in the 1950s) it could only be given if the person was a voluntary patient with informed consent.

5.12 Transfer (s. 28)

A "transfer" occurs whenever an involuntary patient moves from one mental health centre to another. The transfer is authorized on Form K, by the provincial director on the recommendation of the sending and receiving officers in charge. New Form Gs at the receiving centre are not required because the *MHSA* does not specifically require them and an admission does not have to be at where the physician has admitting privileges. Copies of the completed form, which include the reasons for the transfer, must be provided to the patient, the official representative, nearest relative and any proxy or personal guardian. An appeal to the review panel against the transfer can be made using Form N. However, there is no appeal to the review panel against a transfer order (Form L.1) for a patient detained in a mental health centre who is to be transferred to another mental health centre in the same municipality.

5.13 Discharge from a mental health centre (s. 31)

Discharge Voluntary patient (s. 31(3))

Voluntary patients can discharge themselves any time they want. However, if a nurse considers that a voluntary patient needs to stay in the facility because they may meet the involuntary admission criteria, the patient can be held for up to three hours until a physician or resident in psychiatry examines the person and does or does not issue an involuntary admission certificate. (s. 30.1) (New 2015) This is primarily a patient safety provision. Discharge plans are discussed below.

Discharge Involuntary patient (s. 31)

Discharge from involuntary status can occur in five ways:

1. Patient No Longer Meets the Criteria

The attending physician no longer considers the person meets the involuntary admission criteria. Certain people must be informed.

> s. 31(1) "If the attending physician is of the opinion that a person detained pursuant to section 24 no longer meets the criteria for a certificate set forth in clause 24(2)(a), the attending physician shall:
> (a) issue an order in the prescribed form revoking any certificate then in effect [Form H];
> (b) advise the patient that an order has been issued pursuant to clause (a) and that the patient is no longer subject to detention pursuant to section 24;
> (c) provide an official representative for the region with a copy of the order issued pursuant to clause (a); and
> (d) if the patient requests a copy of the order issued pursuant to clause (a), provide him or her with a copy."

With the physician's agreement the patient may become a voluntary patient.

2. Certificates expire

If the time limit runs out on a certificate the patient must be discharged unless new certificates are provided but the person could become a voluntary patient. The patient must be informed:

"[the] attending physician shall immediately cause the patient to be informed in writing that: (a) the certificate or certificates have expired; and (b) he or she is no longer subject to detention or treatment [involuntary]." (s. 31.1)

Form L.3 is used to inform the patient.

3. Review panel decision

If a review panel finds that the person does not meet the involuntary admission criteria the panel orders a discharge. The panel chair transmits the report to the patient, the nearest relative, the officer in charge and others. (See **Appendix 9: Review Panel and Official Representative Procedures**) Again, the person could become a voluntary patient.

4. Community Treatment Order (CTO)

As part of their discharge plan some involuntary patients are discharged from the mental health centre directly on to a CTO, if they meet the criterion. However, a person can be put on a CTO anytime within two years of an admission.

5. Unauthorized absence over 21 days or leaves province

If the patient is on unauthorized absence from the mental health centre for 21 days or more or leaves the province they are discharged.

Discharge planning

The importance of good discharge planning, which includes linking hospital and community staff, involving family and supports and rehabilitation and recovery plans before the person leaves the inpatient setting, are well known to mental health professionals. Without this planning, relapses and an impeded recovery process are likely.

The *MHSA* is not a document that outlines practices, so it does not address these issues directly, but s. 27 calls on the physician to endeavor to "provide the person with care and treatment with a view to the result that the detention of the person in the mental health centre will no longer be required."

Although the section addresses the current episode of hospitalization, it seems reasonable to think that there is also an inference that what is done will help prevent future involuntary hospitalizations. Similarly the CTO sections require there to be a community treatment plan designed to reduce the need for the CTO. (s. 24.7) The importance of good discharge planning cannot be over-emphasized.

Chapter 6

APPEAL AND REVIEW PROCEDURES (Section 32 to 36)

The function of the review panel and the official representative (who plays an important role in informing patients about their right to appeal to the review panel and helps them with this right) are discussed in **Appendix 9: Review Panel and Official Representative Procedures**.

6.1 Reasons for appealing to the review panel

If an involuntary patient wants to be discharged or become a voluntary patient the involuntary patient should speak to his or her attending physician. If the attending physician does not agree that the patient should be discharged or that the patient should be a voluntary patient, the patient or the patient's nearest relative, proxy, or personal guardian can submit an appeal of that decision to the review panel.

Other decisions that can be appealed to the review panel include the review of a community treatment order, the transfer of an involuntary patient from one mental health centre to another mental health centre that is not within the same municipality, and proposed ECT.

6.2 Review panel membership

Review panel members are appointed by the minister and each panel consists of a lawyer, a physician and a person who either has a background or interest in mental health.

6.3 Notification of review panel functions

Notification of the function and how to contact the review panel is given, on involuntary admission, to the patient, a nearest relative, proxy or guardian if any and to the official representative. If the patient objects to the nearest relative being informed because it would endanger the patient's health or safety or be an unreasonable invasion of privacy the attending physician, after consulting with the official representative, may withhold the information and make a record of the reasons for this. (s. 33(3) to (5))

6.4 Who submits an appeal and what happens?

A patient or the official representative or someone else on the patient's behalf can submit an appeal to the review panel in relation to the patient's detention or community treatment order using Form N. The review panel hears the appeal and may require or allow staff or other interested people, for example, families to present evidence.

The decision in writing is usually made within a few hours of the hearing but must be made "before the end of the third business day following the day that the appeal was received." (s. 34(9)) Copies are provided to the appellant, the appellant's nearest relative, proxy or personal guardian, official representative and the officer in charge of the mental health centre.

6.5 Review panel decision appealed to the court

The patient, the patient's nearest relative, proxy or personal guardian, or the official representative, may appeal the review panel's decision to the Court of Queen's Bench if the certification being appealed is still valid. An appeal to the court can be launched even if the patient does not want that to happen. There is no appeal to the court on a transfer decision. The mental health centre may not appeal a review panel decision to the court. Appeals to the court must be made within 30 days of the date of the review panel decision.

6.6 Deemed (automatic) review panel appeals: involuntary admission and CTOs (s. 34)

As long as an involuntary inpatient has not made a voluntary appeal to the review panel in the previous 21 days, the review panel must conduct a review, even if the patient does not want a review, in the following timeframes:

- For patients on their first set of s. 24 certificates, after the expiration of 21 days.
- Thereafter at Six monthly intervals.
- There is no deemed appeal if the person has had a voluntary appeal within the past 21 days.
- For patients on a community treatment order, the deemed appeal is required every six months. Again there is no deemed appeal if a voluntary appeal has occurred within the past 21 days.

Chapter 7

MENTAL HEALTH APPROVED HOMES, CONFIDENTIALITY, LIABILITY and REGULATIONS

7.1 Approved mental health home (s. 37)

"Mental health approved home" is defined in *The Mental Health Services Act (MHSA)* as "any building, premises or place" which has a valid certificate or licence for the purpose. (s. 2(k)) A mental health approved home is a small home with not more than five people where the operator and building have been licensed to provide a home including necessary care for a person with a mental illness who needs this extra structure to live successfully in the community. The licensing is carried out by regional health authority staff. Placements are made by regional staff as are care for the clients and supervision of the home. Appeals against regional decisions are addressed by the ministry. The *MHSA* section 37 and the Regulations for the *MHSA* cover these issues and more information is available in the Mental Health Approved Home Operators' Manual.

7.2 Confidentiality

Except with respect to mental health approved homes, the former confidentiality sections of the *MHSA* now reside with *The Health Information Protection Act (HIPA)* except the *MHSA* Regulation 22(1) makes it clear that information needed by the review panel can be given without the patient's consent and must be provided within 24 hours after the review panel receives notification. (See **Appendix 9: Review Panel and Official Representative Procedures**)

The provisions of *HIPA* are very similar to those under the previous *MHSA*. (See **Appendix 10: Collection, Use and Disclosure of Personal Health Information**) *HIPA* is summarized in **Appendix 2: Family and Friends Involvement** as it applies to people assisting a person to receive treatment and remain well.

7.3 Liability and legal immunity (s. 39)

For people working under or associated with the *MHSA* the *Act* provides "protection" against lawsuits where the person has acted in "good faith." Section 39 details this:

> s.39 "No action lies or shall be instituted against any person who performs a duty, exercises a power or carries out a responsibility pursuant to this *Act* or the regulations for any loss or damage suffered by any person by reason of anything in good faith

done, caused or permitted or authorized to be done, attempted to be done or omitted to be done, by that person, in the performance or supposed performance of that duty, the exercise or supposed exercise of that power or the carrying out or supposed carrying out of that responsibility."

s. 40 "No prosecution for an alleged contravention of this *Act* shall be commenced more than two years after the date of commission of the alleged contravention."

It is usually wise to consult with a lawyer regarding potential or actual lawsuits.

7.4 Regulation making powers (s. 43)

The *MHSA* section 43 lists a large number of areas within which the cabinet of the provincial government may issue regulations including forms. The *Act*, Regulations and Forms, together with a description of the forms, are in this Guide.

APPENDICES:

Appendix 1

Personal Rights and *The Mental Health Services Act*

The Mental Health Services Act (MHSA) provides access to mental health treatment especially when a mental illness hinders a person from realizing they have a treatable illness.

Personal Rights and Mental Health

Understand your rights under *MHSA*.

In Canada, you have many protections from discrimination because of mental disability.

Section 15 of the Canadian Charter of Rights and Freedoms says people must be treated as equal. Each person can expect to be treated fairly even though there may be differences of nationality, race, colour, religion, sex, age, mental or physical disability.

No one is allowed to discriminate against you for any reason including a mental disability.

General rights

The law says people must take your ability into account. They must treat you fairly and equally. Mental health services must be provided with the same consideration for all people.

Agreeing to receive mental health services

Any person may ask for and receive mental health services. If you ask for services:

- You have the right to accept or refuse them.
- You must give consent before you can be examined or treated.

If you cannot understand what this means, your nearest relative may explain this for you **OR** someone else may give permission if you have appointed someone else in a health care directive or applied to a judge to name someone else. If you are a voluntary inpatient and wish to leave treatment, a nurse can require you to stay for up to three hours for a doctor's examination if the nurse thinks it is necessary.

Services Against Your Will

Perhaps you need care and treatment for your mental health, but you are unable or unwilling to ask for help.

Under exceptional circumstances, the *MHSA* allows for you to receive care and treatment without your consent. The *Act* also protects your rights when this happens.

Examination against your will

A person may be ordered to be examined by a psychiatrist. This can happen in the following ways:

- A doctor examines you. The doctor believes you have a mental disorder and need treatment. The doctor writes a certificate (Form A) saying you must be examined by a psychiatrist. An authorized (prescribed) mental health professional who may be a resident in psychiatry or a nurse may examine you instead of a doctor if a doctor is not available.
- Another person believes you have a mental disorder. That person presents evidence to a judge. The judge writes a warrant saying you must be examined by a psychiatrist.
- A police officer believes you have a mental disorder which will probably make you harm yourself or others, or make your illness get worse if you are not treated.
- You are in another province and are admitted against your will. Then you may be moved back to Saskatchewan to be examined.
- You are charged with an offence. A judge orders that you be examined by a psychiatrist.
- You have been held under the Criminal Code and you have to be examined.
- You are under a Community Treatment Order and have not met the terms. Your doctor orders an examination.

The examination must be done promptly. You have the right to:

- be told the reasons for the examination;
- contact a lawyer;
- receive a copy of any certificate, warrant or order that says you must be examined.

Admission against your will

You may be admitted to a mental health centre in a hospital and held there against your will. This can happen in three ways:

- under medical certificates;
- under orders where you have been charged or convicted of a criminal offence; or
- under a court order for long-term detention.

To be held under medical certificates, two different certificates are signed by two different doctors. At least one doctor must be a psychiatrist and one can be a resident in psychiatry. Both doctors must certify the following:

- you have a mental disorder and need treatment and supervision which can only be provided in a mental health centre, often in a hospital;
- your mental disorder keeps you from fully understanding that you need treatment and supervision, so you cannot make an informed decision; and
- your mental disorder will probably make you harm yourself or others, or make your illness get worse if you are not treated.

In an emergency you may be held under one medical certificate for up to three days. Where two doctors have written medical certificates, you may be held for up to 21 days. If your doctor believes you need to stay longer, two more medical certificates may be written to make you stay up to another 21 days.

Treatment

If you are asking for treatment and care, you cannot be treated without your consent.

If your mental illness keeps you from understanding that you require treatment, and you won't give your consent, you may be treated without your consent in the following situations:

i. you are being held under medical certificates in a special mental health centre in a hospital;

ii. you are being held under a court order for long-term detention; or

iii. you are placed under a Community Treatment Order.

There are rules that must be followed when you are treated without your consent:

- your doctor must explain the treatment to you and, wherever possible, consider your views depending on your medical condition;
- before electroconvulsive therapy (ECT) is given, two psychiatrists must examine you and write special certificates; and
- psychosurgery and experimental treatment are not allowed.

Community Treatment Order (CTO)

Your psychiatrist may place you under a Community Treatment Order, which allows you to live in the community while receiving treatment. This can only happen if:

- you have a mental disorder which requires treatment and supervision in the community, and you do not need to be in hospital;
- you have been hospitalized in the last two years including the current admission;
- your mental disorder could make you harm yourself or others, or make your illness get worse if you are not treated;
- the services which you need are available in the community;
- your mental disorder keeps you from understanding that you need treatment and supervision, so that you cannot make an informed decision; and
- you are able to co-operate with the CTO.

If a second doctor examines you and supports the CTO written by your psychiatrist, a CTO is issued for up to six months and can be renewed by one doctor for six month periods. You must comply with the order. You must then follow prescribed medical treatment and attend appointments with your psychiatrist or case manager.

Protection Under the *Act*

When a certificate is issued on you and you are required to attend for treatment against your will, you have the right to special protection under the *Act*.

Official representatives

Official representatives are usually lawyers with expertise in the mental health field. They have been appointed to help people who have been detained under the *MHSA* understand their rights.

An official representative:

- Will visit you if you are being treated, transferred or ordered to receive ECT against your will. He or she will visit you within 24 hours if you are being held under a certificate.
- Is notified if you are examined against your will. He or she may contact you.
- Is notified if you are placed under a CTO. He or she may contact you.

You may ask to speak with an official representative at any time.

Review panel

A review panel has been set up in your health region to investigate appeals. There are three people on the panel. The chairperson is a lawyer, the vice chairperson is a doctor, and the third person is a citizen.

- You may appeal to the review panel if you disagree with being held, transferred or are to be treated with ECT against your will.
- If you appeal, the review panel will hold a hearing. This will happen within three business days of your application.
- An appeal will be sent to the review panel for you automatically if you are held for longer than 21 days and you did not appeal the first set of certificates. If you are under a CTO for longer than six months, an appeal will be sent to the review panel automatically.
- You may also appeal to the review panel if the doctor has ordered ECT. ECT is not allowed while the review panel is reviewing your appeal.

Your rights at a hearing

You have the right to:

- be present at an appeal hearing;
- give evidence;
- see and hear all evidence given by others;
- cross-examine people;
- be represented by any other person; and
- ask an official representative to accompany you and provide help.

There is no charge for official representative or review panel services.

The authority of the review panel

The review panel can over-rule decisions which have been made, including:

- decisions to keep and treat you in hospital;
- transfer you;
- give you ECT; or
- give you treatment in the community against your will.

The review panel has three business days to give you its decision.

If you do not agree with a decision made by the review panel on any matter except ECT, you have the right to appeal to the Court of Queen's Bench.

Confidentiality

All information about your diagnosis and treatment is confidential. Information will only be released:

- to persons who need it to give you treatment;
- to other persons with your written consent; and
- otherwise as required by law.

You have a right to information about yourself. It may be kept from you only if it will hurt you or another person. In case of dispute, you may appeal to the Privacy Commissioner for an order to release the information.

For More Information

If you would like more information about your rights under *The Mental Health Services Act*:

- ask a psychiatrist or other mental health professional;
- ask an official representative in your health region; or
- contact the mental health service of your local health region.

Appendix 2

Family and Friends Involvement

Introduction

Families and friends (referred to here as "families") of people with serious mental health problems often want to help, but find it difficult because the person will not go to a doctor for diagnosis and treatment voluntarily. *The Mental Health Services Act (MHSA)* exists to help these people, and indirectly their families. The *MHSA* authorizes involuntary admission and treatment in a mental health centre for people when professional staff determines that they meet certain criteria.

This appendix explains how the *MHSA* works and what role families can play in using the *MHSA* and other laws to help their relative receive treatment and protect their rights. It also covers families' involvement with the *MHSA* when a person is in hospital (mental health centre) and after discharge. The following issues are addressed:

1. Helping to obtain hospital treatment
    - 1.1 Where to get advice
    - 1.2 Voluntary admission and treatment
    - 1.3 Methods of accessing involuntary admission
    - 1.4 Physician, peace officer, judge
2. In the hospital
    - 2.1 Notices from the mental health centre
    - 2.2 Treatment planning input and authorization
    - 2.3 Temporary absence
3. Discharge from the hospital
    - 3.1 Discharge planning
    - 3.2 Community Treatment Orders
    - 3.3 Mental health approved homes
4. Information issues
    - 4.1 Helpful information for a physician, peace officer, judge, or review panel
    - 4.2 Obtaining information from and providing information to clinicians
    - 4.3 Complaints

1. Helping to obtain hospital treatment

1.1 Where to get advice

It is important for families to obtain advice when trying to help a person, especially when that person does not seem to want help. Advice can be helpful because the law is not easy to understand and the best ways of using it in a particular person's situation vary. Persuading a person to seek help, which may turn out to be involuntary help, can be upsetting to the person. Advice on these issues is often available from a family doctor, psychiatrist, mental health centre outpatient department, Schizophrenia Society of Saskatchewan, Canadian Mental Health Association, lawyers, Healthline 811 or in an emergency, by calling 911.

1.2 Voluntary admission and treatment

The *MHSA* provides for voluntary admission if a physician with admitting privileges to a mental health centre examines the person and agrees and the person can make an informed decision to consent to the admission.

Voluntary admission is preferred – it is recommended that families encourage voluntary admission when they believe the person needs hospital services.

A voluntary patient is free to discharge themselves from the mental health centre at any time, unless a nurse believes the person meets the involuntary admission requirements. In that case, a nurse can now require the patient to stay for up to three hours for an examination by a physician. This is a protection for patients who may leave the hospital and harm themselves or others (see section 30.1 of the *MHSA* for more information).

If the patient is a child and is not able to make decisions for themselves, a parent or guardian, in consultation with the physician, can give permission for the child to be admitted to the inpatient mental health centre for treatment.

The *MHSA* does not prohibit an adult who lacks the capacity to make a voluntary admission decision to be admitted by a substitute decision maker under *The Health Care Directives and Substitute Health Care Decision Makers Act*. If there is no proxy or personal guardian, the nearest relative may make the decision for the person.

Voluntary patients consent to their own treatment. However, if a person is not capable of making a treatment decision (including a child), the nearest relative, proxy or personal guardian can give consent for treatment.

Who is the nearest relative, proxy and personal guardian?

The person's nearest relative (see list in s. 25.1) makes decisions, for a voluntary patient, if the patient is not capable of making the decision and also receives notices about the

person's rights under the *MHSA* for involuntary patients. However, if the person when capable has appointed a proxy in a health care directive or the court has appointed a personal guardian, that person, rather than the nearest relative makes the decisions and receives the notices.

Methods of accessing involuntary admission: physician, peace officer, judge

When someone will not agree to or is not suitable for a voluntary admission, there are three methods of arranging for an involuntary admission. Which one is appropriate in a particular situation will depend on urgency, available resources and other factors but the usual approach is:

1. Through a physician or prescribed health professional (the preferred method);
2. Through a peace officer (police) if the physician method is not practicable under the circumstances; or
3. Through a judge if the other two routes are not reasonable.

1. A physician or prescribed health professional (s. 18)

The person is persuaded by anyone, often by family members, to see a physician or a "prescribed health professional" (a nurse or resident in psychiatry authorized to issue examination certificates if a physician is not available).

Physician/Prescribed Health Professional Examinations can take place at any location, including the person's residence, but often happen in hospital emergency rooms.

Following an examination*, a "Certificate of Physician or Prescribed Health Professional that a Psychiatric Examination is Required" (Form A) is issued if the person:

> "(a) …is suffering from a mental disorder and requires a psychiatric examination to ascertain whether he or she should be admitted to a mental health centre pursuant to section 24; and
> "(b) refuses to submit to the examination mentioned in clause (a)." (s. 18(1))
>
> **The Physician/Prescribed Health Professional can use information provided by the family in reaching their decision to require a psychiatric exam. See the "Information Issues" section for more information.*

The professional who issued Form A makes arrangements with a physician who has admitting privileges to a mental health centre for the person to receive a psychiatric examination.

The person can be taken to the mental health centre by anyone including family members, but guidance as to whether that is wise should be sought from the person who issued the

Form A. It may not be appropriate for family because the person may not be happy about having to have an involuntary examination. A peace officer (police officer) can be called by the person who issued Form A to transport the person for the psychiatric examination.

The certificate for an examination, Form A, can be used as authority to apprehend a person to take the person for a psychiatric examination for up to seven days after the initial examination.

The psychiatric examination usually takes place at a mental health centre and must be completed within 24 hours of the person's arrival at the centre. (See **Appendix 5: Completing Form A: Certificate of Physician or Prescribed Health Professional that Psychiatric Examination is Required**)

It may be possible for a psychiatrist with admitting privileges to see the person directly for a Form G (Certificate of Medical Practitioners for Compulsory Admission of a Person to a Mental Health Centre) examination without the need to go through a Form A assessment.

If the examination at the mental health centre finds the person meets the criteria for involuntary hospitalization, the first of two required Form Gs is issued, which allows the person to be held and treated for up to three days following the day he or she was admitted on. During that time another physician, usually a psychiatrist, must complete another examination, and a second Form G is completed. This will admit the person into the mental health centre for up to 21 days. (See **Appendix 6: Completing Form G: Certificate of Medical Practitioner for Compulsory Admission of a Person to a Mental Health Centre**)

It may be possible for a psychiatrist with admitting privileges to see the person directly for a Form G examination without the need to go through a Form A assessment.

2. A peace officer (s. 20)

A peace officer (officer) who has reasonable grounds to believe that the person meets the *MHSA* criteria could apprehend the person and take the person to any physician for an examination to determine if the person needs a psychiatric examination.

The peace officer must have:

> "reasonable grounds to believe that the person is:
> (a) suffering from a mental disorder; and
> (b) likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre."

Information you have on symptoms or behaviour of the person that address these criteria, verbal or written, should be given to the officer.

A crime does not have to be committed or prevented for a officer to be involved, only that the criteria in s. 20 of the *MHSA* are met.

Following the 2015 amendments to the *MHSA*, the officer is not confined to assessing the person acting in a "public place" and the person who is mentally disordered does not have to be "causing a disturbance by acting in a manner that would normally be considered disorderly." The person could be sitting quietly, but dealing with suicidal intentions or other delusions that would qualify the person for apprehension. The officer still must have a reasonable belief that if the person is not hospitalized they are likely to cause harm to themselves or others or suffer substantial mental or physical deterioration.

If the officer apprehends the person, the officer takes the person to any physician often to a hospital emergency department, for an examination. The officer informs the person of their rights. (s. 16)

If a Form A is issued by the examining physician, the same process outlined above for physician examinations takes place. If the physician does not issue a Form A, the person is free to leave.

3. A judge (s. 19)

Where it is not possible under the circumstances for the person to have a voluntary examination by a physician (because they refuse to do so, or the peace officer process is not appropriate) a Provincial Court Judge may order the person to a mental health centre for a psychiatric examination.

Any person can apply to a judge to have a person examined by a physician, including a family member, friend or staff of a home or a mental health centre. To speak to a judge, contact the clerk of a provincial courthouse for direction.

If deemed necessary, the judge will fill out a Form B. The person requesting the examination swears an oath to say the information is true and is also required to sign the Form B. The oath you must sign states the information:

> "The informant says that (name and place of residence) refuses to submit to a medical examination and the informant has reasonable grounds to believe and does believe that (name) is suffering from a mental disorder and is in need of examination to determine whether he/she should be admitted to a mental health centre pursuant to section 24 of *The Mental Health Services Act*."

When filling out the Form B, the judge will want to receive the following information:

- that the person has refused to go for a voluntary examination by a physician;
- what signs of a mental disorder the person is displaying; and
- information about likely harm or deterioration if the person is not admitted and treated (See "Information Issues – Helpful Information for a physician, judge, peace officer or review panel" section below for more information).

The family member does not actually have to have physically seen the person recently but must have good reason to believe from other contacts that the person likely meets the involuntary examination criteria.

If the person requesting the examination is concerned about personal safety or retaliation, the judge may grant a request not to reveal their name, or another person involved may provide the necessary information.

If the judge is satisfied with the application, the judge will complete a Form C, Warrant to Apprehend, and make arrangements with a named physician who has admitting privileges to carry out the examination. Form C, the Warrant to Apprehend, does not require the name of the person who laid the information.

The Form C warrant authorizes any peace officer to take the person to the place of the examination. Instead of a peace officer, the judge can authorize a named person (e.g. family member or staff) to carry out the warrant and convey the person for the examination if that is appropriate.

The physician examines the person and if the person meets the involuntary admission criteria, the physician will issue a Form G and the person can be admitted. Within three days, a second examination will be performed, and if a second Form G is issued, then the person can be detained at the mental health centre for up to 21 days.

2. In the mental health centre (hospital)

Once the person is involuntarily admitted to a mental health centre, the person may be detained for up to 21 days. That can be extended with renewal examinations every 21 days.

If your relative or friend is an involuntary patient, you are encouraged to stay in contact with them, take them out for visits (if possible), and be involved in their treatment planning. You also may want to provide relevant information to staff aimed at helping the person, and to keep you informed about how they are progressing. You will also want to see that their legal rights are protected through the official representative and review panel.

2.1. Review panel, notice and action

When a person is involuntarily admitted, a notice will be given to the patient and sent to the nearest relative, any proxy, any personal guardian and the official representative about the review panel. The review panel can decide if the person can leave the hospital when the physician believes they should not. (See **Appendix 9: Review Panel and Official Representative Responsibilities**) The review panel can be contacted through your local mental health centre.

If you think the person should not be in the mental health centre, contact the official representative to discuss if a hearing with the review panel should be arranged. You should note that the official representative acts on behalf of the patient and will advise if your request is a conflict of interest.

If you learn that the review panel is conducting a hearing and you have information suggesting the person should not be discharged, contact the review panel chair and ask to be able to provide evidence at the hearing. The official representative may also help you if that is not considered a conflict of interest.

Hearings are conducted if a person requests them. Hearings are also automatically conducted after the first 21 days and then every six months after that, although usually people do not stay that long in hospital. However, there is no right of appeal if a review panel has been held in the preceding 21 days.

The official representative, who is usually a lawyer appointed by the minister, explains the patient's legal rights to them when the patient is admitted. The official representative may also help the person launch an appeal to the review panel and help the person at the appeal. The official representative may be contacted through your local mental health centre.

The review panel usually decides on the day of the hearing if the person meets the involuntary admission criterion but must issue a written report within three days.

If the decision is that the person did not meet the involuntary admission criterion on the day of the hearing, the person is immediately discharged from involuntary status but may stay as a voluntary patient.

The "Information Issues" section below will help you gather information relevant for the review panel hearing. If the chair agrees, you may have a lawyer or other person help you present the information and answer questions.

2.2. Treatment planning and authorization

- **For a voluntary admission:**
  If the person is not capable of making a treatment decision the decision is made by the nearest relative, proxy or guardian (see Voluntary admission above).
- **For involuntary admission:**
  The attending physician decides on the type of treatment after consulting with the patient and considering the patient's views depending on the patient's medical condition.

Families may provide helpful information to the physician from past experience with medications and patient preferences. There is no requirement in the *MHSA* for the physician to request this information, other than the physician must act in accordance with "good medical practice." (s. 25)

2.3. Temporary absence

Involuntary patients may be provided temporary absences from mental health centres, if authorized by the attending physician, to receive health care or other services that cannot be provided by the mental health centre. Temporary absences can also be approved by the attending physician for "activities that will be of benefit to the patient". This could include for example, birthdays, day outings, rehabilitation or recreational activities and longer periods at home as part of a rehabilitation plan. (s. 29(1)(b))

If the patient does not abide by the conditions that the physician outlined for the temporary absence, the mental health centre is called and the person can be returned by the police or anyone named.

3. Discharge from the hospital

3.1. Discharge Planning

Family involvement in discharge planning can be very helpful to the clinical team by providing information, participating in decision making where appropriate, and understanding the plan in order to assist the person on discharge. After discharge, some people can receive additional help through the *MHSA* with a Community Treatment Order (CTO) or living in a mental health approved home.

3.2. Community Treatment Order (CTO)

A Community Treatment Order (CTO), for a person who qualifies, requires the person to follow a treatment plan to maintain their well-being while living out of the hospital. If the person does not follow the plan, he or she may be admitted to hospital.

CTOs are particularly helpful with people who respond well to treatment in hospital but find it difficult to maintain treatment in the community, have a relapse and are re-hospitalized. CTOs can also be helpful in early episodes of illness to help prevent multiple relapses.

If you think a CTO may be helpful for your relative or you would like to be involved in the treatment plan developed for a CTO, discuss this with the attending physician.

A CTO is issued after two independent psychiatrists find that the person meets the CTO criteria.

- The criteria for a CTO include: suffering from a mental disorder and,
  - in need of treatment or care and supervision that will be provided in the community;
  - without these services the person is likely to cause harm to himself or herself or to others, or to suffer substantial mental or physical deterioration;
  - unable to fully understand and to make an informed decision regarding the need for treatment; capable of complying with the treatment plan (may not want to); and
  - in the previous two year period has had at least one admission (including the present admission) either voluntary or involuntary or has had a previous CTO. (Note: prior to 2015, three admissions or 60 days in hospital were required).

The CTO treatment plan, lasting up to six months, will state requirements that the person must comply with and can include where the person resides. The name of the person responsible for supervising the CTO is recorded. Family members may be involved by staff in developing, carrying out or monitoring the community treatment plan. A copy of the CTO is provided to the patient, nearest relative, proxy or guardian, patient and official representative. (s. 24.3(3))

If the person does not comply they can be taken for an examination. Contact the supervisor of the CTO or attending physician if you become aware of a problem.

Anyone can appeal to the review panel to have the CTO cancelled and there are regular automatic reviews for CTOs. Families may want to provide evidence that the person should come off or remain on the CTO. (See **Appendix 9: Review Panel and Official Representative Procedures**)

3.2. Mental health approved homes

If a person needs assistance with housing, there are a variety of options which can be discussed with mental health centre staff. One option for those requiring 24 hour supervision is a mental health approved home.

A mental health approved home is a small home (with no more than five people) where the operator and building have been licensed by the regional health authority. They provide a residence (including necessary care) for a person with a mental illness who needs this extra structure to live successfully in the community. The licensing is carried out by regional staff. If you think your relative needs approved home services, discuss this with the treating team member who is your contact. See the Mental Health Approved Home Operators' Manual for more information.

4. Information issues

4.1. Helpful information for a physician, peace officer, judge or review panel

Information is needed for a physician to complete a certificate for an involuntary psychiatric examination, for the physicians at the mental health centre to complete their certificates, for a judge to issue a warrant, for a peace officer to apprehend someone and for a review panel hearing. Some information is gathered directly from the patient from what these people see and hear. However, often the patient cannot provide all the relevant information because of the illness or because the person is not aware of it. People who know the person, like family members, can be very helpful in providing additional accurate information.

The most helpful way to share this information is to record incidents, symptoms and situations as they occur (keeping a note of the date and time). In summarizing this information for the physician and others, consider the following questions:

1. **Does this person have a "mental disorder"?**

   Examples of symptoms include delusions, hallucinations, confused or illogical thinking, depression, manic symptoms, difficulty relating to others.

2. **Does this person refuse to have a psychiatric examination?**

   For example, this person has not gone to see a doctor when that was suggested due to the nature of the symptoms (delusions may lead the person to refuse to see a doctor, and for a family member to insist they seek medical attention may be alienating or dangerous).

3. **Is this person likely to cause harm to themselves or others, or suffer substantial mental or physical deterioration?**

   Harm: the harm caused by the mental disorder can include more than bodily harm and include psychological, vocational, social, financial or family harm. For example: has threatened or actually hurt people; the delusions may prompt violence; is spending huge amounts of money because of manic symptoms; is in danger of losing a job because of erratic behaviour caused by the illness; is intimidating their children.

   Deterioration: showing early signs of becoming ill as in previous episodes, has stopped taking medication and symptoms are likely to re-emerge, is not eating and losing weight dangerously.

4. **Does this person need psychiatric treatment?**

   For example, the person exhibits symptoms such as hallucinations or anxiety that usually need psychiatric treatment; is being treated now; has been treated in the past.

5. **Unable to fully understand his/her need for treatment?**

   For example: lacks insight into his or her need for treatment. Be specific and give examples, such as the person says "there is nothing wrong with me", refuses to see a doctor, has delusions or lack of understanding about treatment, or has unreasonable fears of treatment.

4.2. Obtaining and providing personal mental health information

Family and other people often need information to help the person and assist in their treatment. As well, families often have information that would be helpful for clinicians. How information is collected, used and released must now conform with *The Health Information Protection Act (HIPA)*. Previously these rules were in the *MHSA*. There is a detailed discussion of *HIPA* in **Appendix 10: Collection, Use and Disclosure of Personal Health Information** but a brief description is provided here.

The basic principle of *HIPA* is that people must give consent for how information about them is collected and used. That information must be held in confidence and can only be disclosed to others if the person consents, or *HIPA* deems consent or allows disclosure without consent.

Sometimes people with a mental illness cannot, because of the illness, provide all the information a physician or other health professional needs to help them. The issue may be that the person does not then have the capability to understand the implications of providing information, or the person may not have the information. If the information cannot be provided by the person, *HIPA* allows anyone, including family and friends, to provide relevant information without the person's consent (this is referred to as indirect collection).

The best way to receive medical or treatment information from a mental health or other mental health care staff member is to have the person provide consent for staff members to provide information to you. Any relevant information, except that which may be harmful, can be released.

In some cases, a person with an illness will not want information shared, but the family caregiver may feel that is essential for the person's health. Examples can include:

- side effects of medication;
- best ways of handling medication refusal;
- prognosis;
- likely effects if treatment is stopped; and
- concerning behaviours they have witnessed or experienced.

Generally, the information is being requested for the purpose for which it was collected and it is necessary for the person to know and hence it can be disclosed.

4.3. Complaints

There is no formal way of addressing complaints in the *MHSA*. The recommended approach for launching a complaint is to start with the person most directly involved with the person's care.

If that does not resolve the issue, speak to the management. For mental health services this might include the clinician, officer in charge, regional director or chief psychiatrist.

If it is not resolved by management, each health region has a patient Quality of Care Coordinator (QCC) to assist individuals and families with questions or concerns about health services in their region.

You can also take your complaint to the provincial Ombudsman or to professional colleges or associations such as the College of Physicians and Surgeons or College of Psychologists.

Mental health organizations such as the Canadian Mental Health Association or Schizophrenia Society of Saskatchewan may provide advice and support.

For more information, visit the Government of Saskatchewan website Resolving Health Care Concerns and Complaints page.

Appendix 3

Designated Mental Health Centres (inpatient units)

The current inpatient units (now called mental health centres) that may accept involuntary patients were all designated by the minister as mental health centres, mental health clinics, or psychiatric wards under *The Mental Health Services Act* prior to the proclamation of the amendments to *The Mental Health Services Act*. These designations continue to be valid. However, with the proclamation of the amendments the responsibility for future designations rests with the regional health authorities under *The Regional Health Services Act* and The Facility Designation Regulations.

For more information or contact information, search the Health Regions and Services map on Saskatchewan.ca.

The list is as follows:

BATTLEFORDS MENTAL HEALTH REGION

Name of Facility	Place or Portion of Building	Type of Facility
Saskatchewan Hospital North Battleford	Box 39 1 Jersey Street North North Battleford, SK S9A 2X8 Prairie North Regional Health Authority Phone: 306-446-7938	Mental Health Centre
Battlefords Mental Health Centre	Battlefords Union Hospital Mental Health Centre Wing 1092 – 107th Street North Battlefords, SK S9A 1Z1 Prairie North Regional Health Authority Phone: 306-446-6500	Mental Health Centre

MOOSE JAW MENTAL HEALTH REGION

Name of Facility	Place or Portion of Building	Type of Facility
Mental Health and Addictions Unit	Moose Jaw Union Hospital 3rd Floor West 4th Floor West 455 Fairford Street East Moose Jaw, SK S6H 1H3 Five Hills Regional Health Authority Phone: 306-691-6464	Mental Health Centre

NORTHERN MENTAL HEALTH REGION

(nil)

PRINCE ALBERT MENTAL HEALTH REGION

Name of Facility	Place or Portion of Building	Type of Facility
Adult Mental Health Inpatient Unit	Adult Mental Health Inpatient Unit Victoria Hospital 1200-24th Street West Prince Albert, SK S6V 5T4 Prince Albert Parkland Regional Health Authority Phone: 306-765-6053	Mental Health Centre
Child/Adolescent Mental Health Inpatient Unit	Child/Adolescent Mental Health Inpatient Unit Victoria Hospital 1200-24th Street West Prince Albert, SK S6V 5T4 Prince Albert Parkland Regional Health Authority Phone: 306-765-6053	Mental Health Centre

REGINA MENTAL HEALTH REGION

Name of Facility	Place or Portion of Building	Type of Facility
Adult Inpatient Mental Health Services	Level 1D Regina General Hospital 1440 – 14th Avenue Regina, SK S4P 0W5 Regina Qu'Appelle Health Region Phone: 306-766-4321 (1D East) Phone: 306-765-6053 (1D West)	Mental Health Centre
Adolescent Inpatient Mental Health Services	4B Regina General Hospital 1440 – 14th Avenue Regina, SK S4P 0W5 Regina Qu'Appelle Health Region Phone: 306-766-4218	Mental Health Centre

SASKATOON MENTAL HEALTH REGION

Name of Facility	Place or Portion of Building	Type of Facility
Irene and Les Dubé Centre for Mental Health	Irene and Les Dubé Centre for Mental Health Royal University Hospital 103 Hospital Drive Saskatoon, SK S7N 0W8 Saskatoon Health Region Phone: 306-655-0703 (Adult) Phone: 306-655-0702 (Child & Adolescent)	Mental Health Centre
Regional Psychiatric Centre (Prairies)	Regional Psychiatric Centre 2520 Central Avenue Box 9243 Saskatoon, SK S7K 3X5 Saskatoon Health Region Phone: 306-975-5400	Mental Health Centre

SWIFT CURRENT MENTAL HEALTH REGION

Name of Facility	Place or Portion of Building	Type of Facility
Inpatient Psychiatry	Cypress Regional Hospital 2004 Saskatchewan Drive Swift Current, SK S9H 5M8 Cypress Regional Health Authority Phone: 306-778-9522	Mental Health Centre

WEYBURN MENTAL HEALTH REGION

Name of Facility	Place or Portion of Building	Type of Facility
Mental Health Inpatient Unit	Tatagwa View Souris Valley Grounds Box 2003 Weyburn, SK S4H 2Z9 Sun Country Regional Health Authority Phone: 306-842-8398	Mental Health Centre

YORKTON MENTAL HEALTH REGION

Name of Facility	Place or Portion of Building	Type of Facility
Inpatient Psychiatry	Inpatient Psychiatry Yorkton Mental Health Centre 270 Bradbrooke Drive Phone: 306-786-0558	Mental Health Centre

Appendix 4

Voluntary and "Alternative" Admission Procedures

This appendix addresses the procedures for the admission, treatment and discharge of voluntary patients under *The Mental Health Services Act (MHSA)* to a designated mental health centre. Voluntary admission for psychiatric illness, like any other illness, can also occur through a physician with hospital admitting privileges to their hospital beds.

This appendix also discusses "alternative" admissions where a person requires hospitalization but cannot consent to the admission and involuntary admission under the *MHSA* is not appropriate.

Voluntary admissions

- Voluntary psychiatric patients can be admitted to a designated mental health centre under the *MHSA* by a physician with admitting privileges to the mental health centre. This can include children admitted by their parent or guardian and mature minors who are capable of making admission and treatment decisions.
- The *MHSA* does not prohibit an adult who lacks the capacity to make a voluntary admission decision to be admitted by a substitute decision maker under *The Health Care Directives and Substitute Health Care Decision Makers Act*. If there is no proxy or personal guardian, the nearest relative may make the decision for the person.
- Voluntary patients may have been admitted directly or have been involuntary patients de-certified by their attending physician or found not to meet Form G criteria by a review panel, if they voluntarily consent to continuing their assessment or treatment in hospital.
- A voluntary patient who does not need to be in a mental health centre bed or where there are no designated mental health centre beds (e.g. a rural hospital) can be admitted to hospital by their physician with hospital admitting privileges. This is the same procedure as with any other illnesses requiring hospital services.
- The same consent Form is used for voluntary patients under the *MHSA* as patients admitted through a physician's privileges and the informed consent process is the same with one important exception:

  MHSA voluntary patients, who want to leave against medical advice, may be held for up to three hours by a nurse in a mental health centre for a physician with mental health centre admitting privileges or a psychiatric resident to examine them. This detention can occur if the nurse has reason to believe that the person meets the involuntary criterion; that is, harm or deterioration is likely if they

leave. (s. 30.1) If information about a three hour hold, is likely to be relevant for a particular patient, the admitting physician should convey this information to the patient in a sensitive manner.

This three hour hold provision only applies to voluntary patients in the mental health centre. It does not apply to voluntary patients in other parts of the hospital such as an emergency room. Similarly, only a nurse working at the mental health centre may use the provision. Other nurses may not. Of course ordinary provisions to prevent bodily harm in the common law apply in all situations.

"Alternatives" to involuntary admission under the *MHSA*

Mental health physicians are sometimes asked to certify under the *MHSA* a person, often on a medical ward, who is not capable of making a treatment decision but is refusing medical treatment. These people cannot be admitted under the *MHSA* for two reasons:

1. they do not meet the definition of mental disorder that requires treatment for the mental disorder to be advisable; and
2. even if certified they could not be treated involuntarily because the only treatment the attending physician can order without consent is for the mental disorder, not for other medical problems.

The person can be treated under *The Health Care Directives and Substitute Health Care Decision Makers Act*, when they are incapable even when resisting treatment. Section 16(4) states:

> s. 16(4) "Where there is no nearest relative or where a reasonable attempt to find the nearest relative has been made but the nearest relative cannot be found, and a person requiring treatment lacks the capacity to make a health care decision, a treatment provider may provide treatment in a manner and to the extent that is reasonably necessary and in the best interests of the person without receiving a health care decision from the nearest relative if:
>
> (a) the treatment provider believes that the proposed treatment is needed; and
>
> (b) another treatment provider agrees in writing that the proposed treatment is needed."

As the Saskatchewan Medical Association News states, attempting to use the *MHSA* to address medical treatment issues is a contravention of the *MHSA*: "This section gives clear authority to a physician to proceed as necessary when a patient's lack of capacity is determined and no relative or guardian is available to consent on his/her behalf. In this circumstance, the physician would simply document the absence of capacity, the need for the proposed treatment and the corroboration of this opinion by a second physician [or health care provider]." (see s.16(4))

Appendix 5

Completing Form A: Certificate of Physician or Prescribed Health Professional that Psychiatric Examination is Required

This appendix covers the following issues:

1. What is Form A?
2. Who may complete Form A?
3. Where can the examination take place?
4. How does the person get to the examination?
5. Is a Form A necessary before a Form G can be issued?
6. What are the criteria for issuing a Form A?
7. What does "mental disorder" mean?
8. How is it decided if a psychiatric examination is required?
9. How is the Form A examination conducted? What if the person refuses to talk?
10. Completing the Form A
11. Arrange conveyance to the mental health centre physician

1. What is Form A?

Form A "Certificate of Physician or Prescribed Health Professional that Psychiatric Examination is Required" is a Form under *The Mental Health Services Act (MHSA)* Regulations. If a physician without admitting privileges to a mental health centre or a prescribed health profession completes a Form A, that authorizes the apprehension and conveyance of that person for a psychiatric examination (Form G) to determine if the person should be admitted as an involuntary patient. Arrangements must be made by the Form A examiner with a physician with admitting privileges at the mental health centre for the person to be examined as an outpatient to determine if they meet Form G criteria. That physician's name must be recorded on Form A. Only one Form A is required.

Two Form Gs, "Certificate of Medical Practitioners for Compulsory Admission of a Person to a Mental Health Centre", must be completed independently by physicians with admitting privileges to a mental health centre one whom is a psychiatrist, for the person on the Form A to be involuntarily admitted. One Form G may be completed by a resident in psychiatry who is under the supervision of a psychiatrist with admitting privileges, but the resident's supervisor or another resident cannot complete the other Form G (See **Appendix 6: Completing Form G: Certificate of Medical Practitioners for Compulsory Admission of a Person to a Mental Health Centre**).

2. Who may complete Form A?

Any physician who is a "duly qualified medical practitioner within the meaning of *The Medical Profession Act, 1981"* (s. 1(w)) may complete a Form A. If a physician will not be available in a reasonable period, the Form A may be completed by a prescribed health professional.

What is a "prescribed health professional"?

Prescribed health professionals must satisfy the minister that they fulfill the qualifications set out in the Regulations. Regulation 11.1(1) describes the qualifications of nurses and residents in psychiatry necessary for them to be a 'prescribed health professional' with the authority to issue Form A certificates.':

> "For the purposes of section 18 [Form A]and subsection 24.6(1) [CTO non-compliance] of the *Act*, the following are prescribed health professionals:
>
> (a) a resident in psychiatry under the supervision of a psychiatrist who has admitting privileges to a mental health centre;
>
> (b) a registered nurse [or psychiatric nurse] including a nurse practitioner who satisfies the minister that he or she:
>
> (i) is employed by a regional health authority;
>
> (ii) has at least five years' experience in the past 10 years working in the mental health field;
>
> (iii) is entitled to practice pursuant to *The Registered Nurses Act, 1988* [or *The Registered Psychiatric Nurses Act*]; and
>
> (iv) practises in a rural or remote area of Saskatchewan where access to physician services is limited."

However, the prescribed health professional can issue certificates "only if an attending physician is not available and the prescribed health professional has reason to believe that an attending physician will not become available within a reasonable period." (Regulation 11.1(2))

3. Where can the examination take place?

Anywhere, for example at the person's residence, doctor's office, police cells, but it most frequently takes place at a hospital emergency room. If a person will not go to a physician's office the physician or prescribed health professional may visit the person, provided they agree to the examination.

4. How does the person get to the examination?

If the person has to be conveyed for the Form A examination there are two streams:

1. Relatives or friends or staff or even police may bring the person to the medical practioner or prescribed health professional if the person agrees.
    - If the person refuses to have a Form A examination by a physician or prescribed health professional a psychiatric examination (Form G) may still be possible through the action of a peace officer (s. 20) or a judge (s. 18). A warrant issued by a judge authorizes the person to be taken directly for a Form G examination.
2. If the person has been apprehended by a peace officer under s. 20 of the *MHSA*, the officer brings the person for the examination usually at the emergency room of a hospital.
    - Under a Form A, should the person leave before being seen by a physician with admitting privileges to the mental health centre or resident for a Form G examination, the police could (re)apprehend and return the person for examination to be completed under the authority of the Form A.

5. Is a Form A necessary before a Form G can be issued?

Not in all cases. If a person is examined by a physician with admitting privileges, the first Form G can be issued without a previous Form A. That Form G examination can take place anywhere, for example at the individual's residence, nursing home, corrections facility, a clinic or the hospital.

If an individual is under a warrant from a judge, after arrangements have been made with a physician with admitting privileges to a mental health centre, that person goes directly to a Form G examination.

If a physician (who can complete a Form G) agrees, a peace officer using a section 20 apprehension may take the individual directly to that physician for a Form G examination.

6. What are the criteria for issuing a Form A?

The criteria the physician or prescribed health professional uses to issue a certificate Form A are printed on the Form as follows:

> "I am of the opinion that the person is suffering from a mental disorder and requires a psychiatric examination to ascertain whether he/she should be admitted to a mental health centre pursuant to section 24 [involuntary admission] of *The Mental Health Services Act*."

7. What does "mental disorder" mean?

> "'Mental disorder' means a disorder of thought, perception, feelings or behaviour that seriously impairs a person's judgment, ability to recognize reality, ability to associate with others or ability to meet the ordinary demands of life, with respect to which treatment is advisable." (s. 2(j))

This is a functional definition and does not require a specific diagnosis as a number of symptoms or diagnoses could meet the requirements.

Psychiatric symptoms that may qualify can include hallucinations, delusions, depression, mania, thought disorder, aggression, lack of insight etc.

The disorder must be one that treatment is advisable for.

8. How is it decided if a psychiatric examination is required?

Knowing what the criteria the physician with admitting privileges will use in conducting the mental health centre psychiatric examination (Form G) will provide some guidance, although the Form A examiner must only be of the opinion the person needs the examination not that they necessarily meet Form G criteria.

Form G criteria:

"(i) the person is suffering from a mental disorder as a result of which he or she is in need of treatment or care and supervision that can be provided only in a mental health centre;

(ii) as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his or her need or treatment or care and supervision; and

(iii) as a result of the mental disorder, the person is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre." s. 24(2)

9. How is the Form A examination conducted? What if the person refuses to talk?

Form A requires the person to be seen by a physician or prescribed health professional: "I personally examined."

Collateral information from families, staff, involved peace officers or others can assist in fulfilling the requirement of "…after due inquiry into the necessary facts relating to the case" (s. 18(4)(a)) in order to enable the physician or prescribed health professional to form a satisfactory opinion that the criteria for Form A have been met.

If a person refused to speak or denied any problems, observations of the person and credible collateral information could be the basis upon which the opinion is formed.

10. Completing the Form A

1. Complete the identification information.
2. Provide the grounds for the opinion (legibly).
3. Make arrangements with a physician with admitting privileges at a mental health centre. The list of designated mental health centres is in **Appendix 3**.
4. On Form A complete the name of the physician with admitting privileges with whom the arrangements were made.
5. Date and sign – both physician or prescribed health professional and witness signatures are required.

11. Arrange conveyance to the mental health centre physician

Form A "is sufficient authority to any person to apprehend the person …and convey him or her immediately to the place where the examination is to be conducted by the physician who has admitting privileges in a mental health centre mentioned in subsection (1)." (s. 18(3))

Decide on the least restrictive but safe method of transporting the person to the mental health centre or wherever the examination will take place.

The professional completing Form A would contact the ambulance or police, family or other person for the conveyance. Whoever conveys the person retains custody until the mental health centre takes responsibility.

Provide the original Form A to the person conveying the person to give to the examining physician at the mental health centre and retain a copy.

Appendix 6

Completing Form G: Certificate of Medical Practitioners for Compulsory Admission of a Person to a Mental Health Centre

This appendix covers the following issues:

1. What is a Form G used for?
2. Involuntary Admission (Form G)
3. Where do "Form G" patients come from?
4. Who may complete a Form G?
5. What are the timelines for Form Gs?
    a. Examination to writing the Form G.
    b. After admission on a Form A before first Form G
    c. First Form G time to Second Form G
6. After admission, when do Form Gs expire?
7. Where can the Form G examinations take place?
8. Who waits with the person while the Form G is being completed?
9. The Second Form G
    a. Who may complete the second Form G.
    b. What do two Form Gs authorize?
10. Who is informed and when about a Form G being issued?
11. Criteria for Form G
12. Form G Criteria: Questions and answers
13. Completing Form G.
14. Renewal certificates – Form Gs
15. Expiration or cancellation of Form G

1. What is a Form G used For?

Form Gs are used to involuntarily admit and detain a person in a mental health centre or to renew the person's detention. Form Gs must expire or be rescinded when the person is discharged.

2. Involuntary Admission (Form G)

An involuntary admission occurs when two Form Gs "Certificate of Medical Practitioners for Compulsory Admission of a Person to a Mental Health Centre" have been completed and the person is admitted to a designated mental health centre.

- The first Form G is often completed following the completion of a Form A ("Certificate of Physician or Prescribed Health Professional that Psychiatric Examination is Required", see **Appendix 5**). The Form A will have been completed by a physician without admitting privileges to a mental health centre or by a prescribed health professional. Arrangements must be made by the person who completes Form A with a physician with admitting privileges at the mental health centre for the person to be examined as an outpatient to determine if they meet Form G criteria. The name of the physician who will complete the Form G examination must be recorded on Form A. Only one Form A is required. (s. 18(1)(a))
- The Form A provides authority for the person to be apprehended and conveyed immediately to the place where a psychiatric examination that could result in the completion of a Form G is to be conducted. (s. 18(3))
- Two Form Gs provide the authority to involuntarily admit and detain a person in a mental health centre for up to 21 days following the day the person was admitted (or when the first Form G was completed, if the person was already an inpatient).

3. Where do "Form G" patients come from?

Individuals can arrive for a Form G examination either on the authority of a Form A completed by a physician or prescribed health professional, or following a Form A completed by a physician following a peace officer apprehension (often in an emergency room). (s. 20)

A person, apprehended on a warrant from a judge who has made arrangements with a physician with admitting privileges to a mental health centre, goes directly to a Form G examination (no Form A is required). (s. 19)

Some individuals have their first Form G examination without having a previous Form A. These individuals are examined by "a physician with admitting privileges to the mental health centre" (s. 24(1)(a)): or by "a resident in psychiatry under the supervision of a psychiatrist who has admitting privileges to a mental health centre." (s. 24(1)(b))

If a nurse requires a voluntary patient who wants to leave to remain in the mental health centre, the nurse would request a Form G examination. (s. 30.1)

4. Who may complete a Form G?

- A physician who has admitting privileges to a mental health centre.
- A resident in psychiatry under the supervision of a psychiatrist who has admitting privileges to a mental health centre. (s. 24(1))
- At least one of the Form Gs must be completed by a psychiatrist. (s. 24(3))

If a resident completes a Form G, neither the resident's supervisor nor another resident can complete the other Form G. The examinations must be made independently of each other. (s. 24(4))

If it is not "reasonably practicable to obtain the certificates of two physicians at least one of whom is a psychiatrist," one certificate is sufficient authority for a person to be "apprehended, conveyed and admitted to a mental health centre and detained there until the end of the third day following the day on which he or she is admitted." (s. 24(5)(a)) However, the "second opinion about his or her condition is to be obtained as soon as is practicable" but must be obtained within the time limit (three days: see below) (s. 24(5)) in order to detain the person until the end of the 21st day following the date of the first Form G.

5. What are the timelines for Form Gs?

a. Examination to writing the Form G

Any Form G must be completed by an examining physician with admitting privileges to a mental health centre or resident in psychiatry within 72 hours of examining the patient. (s. 24(2)) For example, where a person is not in a mental health centre (e.g. a nursing home or their residence) it would be possible to examine the patient there and within 72 hours, complete the Form G. Similarly, a voluntary patient seen in the hospital could have been examined up to 72 hours previously and if justified, a Form G completed. In practice, physicians usually complete the certificate shortly after the examination.

b. After admission on a Form A before first Form G

A psychiatric examination (Form G) must be conducted "As soon as is reasonably practical, and in all cases within 24 hours, after the person arrives at the place where he or she is to be examined." (s. 18(6))

c. First Form G time to Second Form G

The *Act* envisions two Form Gs being completed before the person is admitted to a mental health centre. However, there are a number of options provided and the maximum times allowed between the first Form G and the second Form G are as follows:

- Both Form Gs completed prior to admission. In this case the time between the first and second Form G can be up to 7 days because s. 24(9)(a) states "No person shall be admitted to a mental health centre: (a) [if not an inpatient] more than seven days after the date of the first of the two examinations on which the certificates are based." Thus, at maximum, the second Form G could be completed on the date of admission, seven days after the first Form G.

- One Form G completed prior to admission. Again, the person shall not be admitted more than seven days after the date of the examination on which the first Form G certificate was issued. In this case, the second Form G after the person has been admitted must be completed before the end of the third day following the day he or she was admitted. (s. 24(9) and 24(5)(a)) Thus at maximum, the second Form G could completed 10 days following the date of the examination which resulted in the first Form G.
- Already an inpatient on Form A or Voluntary. Here, the first Form G starts the detention and the second must be completed before the end of the third day following the date of the issuance of the first Form G. (s. 24(5)(b))

6. After admission, when do Form Gs expire?

When two valid Form G certificates are in place, they expire at the end (i.e. midnight) of the 21st day following the date upon which the first Form G was issued (s. 24(3)(a)) if the person was an inpatient when the first Form G was issued. If the first Form G was issued for a person not yet admitted to a mental health centre, then the Form G certificates expire at the end of the 21st day following the day he or she was admitted on completion of the first Form G. Thus if the first Form G for an inpatient is completed on 1st of the month, both Form Gs will elapse 21 days later on the 22nd of the month. (s. 24(3))

7. Where can the Form G examinations take place?

The first Form G examination may take place at the mental health centre, or anywhere the physician or resident decides (such as an emergency room or nursing home).

The second Form G is usually completed at the mental health centre, but can be issued anywhere.

8. Who waits with the person while the Form G is being completed?

If a person is accompanied by a peace officer after apprehension by the officer (s. 20) the officer stays with the person until a Form A or Form G is completed. If a peace officer does not remain with an individual until that individual can be examined, however, there is a risk that the person could leave without being examined as the authority to detain an individual pursuant to a section 20 apprehension or pursuant to a judge's warrant does not include the authority for that individual's detention to be transferred into the hands of hospital staff. Whoever conveyed the person on a Form A, under s. 18, often a peace officer but not necessarily, maintains custody until the Form G is completed unless other arrangements are in place. The same applies for a peace officer or other person who conveys on a Judge's warrant. (s.19)

9. The Second Form G

a. Who may complete the second Form G

As with the first Form G, physicians, including psychiatrists with admitting privileges to the mental health centre and psychiatric residents under the supervision of a psychiatrist with admitting privileges have the authority to issue the second independent Form G. One of the Form Gs must have been completed by a psychiatrist. If a psychiatric resident completes a Form G, neither that resident or another resident or the resident's psychiatric supervisor may issue the other Form G. (s. 24(3) and (4))

b. What do two Form Gs authorize?

- Two completed Form Gs are authority for a person who is a mental health centre inpatient to be detained until the end of the 21st day following the date of issuance of the first certificate.
- Two completed Form Gs are authority for a person not in a mental health centre, not longer than seven days after the first examination, to be apprehended, conveyed and admitted and detained until the end of the 21st day after he or she was admitted.
- The involuntary hospitalization may be extended by renewal examinations using Form G criteria (see section on renewal certificates).

10. Who is informed and when, about Form G being issued?

The attending physician must provide Form M "Notification Regarding Appeal Procedures" to the patient, the nearest relative or proxy or guardian (if any), and to the official representative when the person becomes an involuntary patient. Form M is generally sent after admission on the first Form G and provides information on the right of appeal and the name and address of the chairperson of the review panel. The official representative visits the patient and explains the patient's rights and obligations. If asked, the official representative also assists the person with a review panel application and hearing.

11. Criteria for Form G

The requirements and criteria for issuing a "Certificate of Medical Practitioners for Compulsory Admission of a Person to a Mental Health Centre" (Form G) are in section 24:

> s. 24(2) "Every certificate issued for the purposes of this section shall be in the prescribed Form [Form G] and is to:
>
> (a) state that the physician has examined the person named in the certificate within the preceding 72 hours and that, on the basis of the examination and any other pertinent facts regarding the person or the person's condition that have been communicated to the physician, he or she has reasonable grounds to believe that:

(i) the person is suffering from a mental disorder as a result of which he or she is in need of treatment or care and supervision that can be provided only in a mental health centre.;

(ii) as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his or her need for treatment or care and supervision; and

(iii) as a result of the mental disorder, the person is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre."

12. Form G criteria: Questions and answers:

There are a number of issues about these criteria which are addressed below in the form of questions and answers:

What does "examined" mean? Must the physician see the person personally or can the examination be done over the phone or from listening to a person talking behind a door?

"Examined" is not further defined in the *Act* or Regulations. However "examine" in the usual medical context means seeing the person personally and asking questions. The Form G examination does not use the word "personally examine" like the Form A, but probably little significance can be read into that. The *Act* is silent on whether there are circumstances where the physician does not actually have to see the person (e.g. behind a closed door or a telephone interview with the patient). The test would be whether on the basis of the examination where the person was not physically observed but using collateral information and considering the context of the risks to the patient or others, whether the physician "has reasonable grounds to believe that" (24(2)(a)) the person meets the committal criteria. The general rule is that the patient must be seen personally by the physician.

What are "other pertinent facts regarding the person or the person's condition that have been communicated to the physician"?

Other pertinent facts, or collateral information, may be used in addition to the examination to decide if the physician has "reasonable grounds to believe" that the person meets the criteria. These facts are often critical to the admission decision, especially when the person is not forthcoming about his or her symptoms. The facts may be provided to the examining physician or requested by the physician, given due consideration to privacy concerns. (See **Appendix 10: Collection, use and Disclosure of Personal Health Information**). The facts may be communicated in writing or verbally by anyone, but sources of collateral information often include family, community physicians, other professionals, police or records from past admissions. Reasonable efforts should be made to verify such "hearsay" indirectly collected information.

Can a certificate be completed solely on the basis a phone conversation with a person other than the subject?

No. There must also be an examination, as discussed above, of the person who will be subject to the certificate.

What does "reasonable grounds to believe" the person meets the criteria mean?

"Reasonable grounds" is the level of proof the *MHSA* requires. This level of proof is below the "beyond a reasonable doubt" used in criminal trials. It is much more like "the balance of probabilities" used in civil trials. Thus "reasonable grounds" means it is more likely than not that this person meets the involuntary admission criterion. "Reasonable grounds" also refers to reasons or evidence upon which the physician has come to the opinion that the individual satisfies the criteria.

Can the examination be conducted over telehealth link or skype?

The *MHSA* does not address examinations over a telelink or skype. Advice should be sought from the professional involved and legal counsel if this is considered.

What are the involuntary admission criteria (s. 24(a)(2))?

All three criteria must be met including:

(i) being found to be a person with a mental disorder who needs inpatient care;

(ii) not being fully capable of making an admission or treatment decision; and

(iii) likely to harm self or others or suffer substantial mental or physical deterioration.

(i) <u>What is "mental disorder"? Does diagnosis matter?</u>

"'Mental disorder' means a disorder of thought, perception, feelings or behaviour that seriously impairs a person's judgment, ability to recognize reality, ability to associate with others or ability to meet the ordinary demands of life, with respect of which treatment is advisable." (s. 2(j))

- This is a functional definition and does not require a specific diagnosis as a number of symptoms or diagnoses could meet the requirements.
- The disorder must be one for which treatment is advisable.
- People are included in the definition of mental disorder if they have symptoms such as depression, anxiety, aggression or delusions for which treatment is advisable, even though they may also have a disorder such intellectual disability, dementia or psychopathic personality which is not amenable to treatment.

How severe must the mental disorder be to issue Form G?

It must be sufficiently severe to require "treatment or care and supervision that can provided only in a mental health centre" that is, an inpatient setting.

(ii) What does "unable to fully understand and to make an informed decision regarding his or her need for treatment or care and supervision" mean?

> "As a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his or her need for treatment or care and supervision." s. 24(2)(a)(ii)

The foundation on which this "capability criterion" is built is that a person with a mental disorder, who nevertheless is fully capable of making an admission or treatment decision, should not be admitted against his or her competent will. Like anyone else who chooses to take risks, they are required to accept consequences of refusing admission no matter how negative for the person or society. The person must be "fully" capable in order not to be admitted because if the usual capability criterion was used, many people, some who may be dangerous to self or others, could not be admitted. The more serious the consequences of a decision such as refusing admission, which might lead to harm to self or others, the higher the level of capability the person should have.

"Fully understand" would include not only understanding the information but appreciating that it applied to the person and to their situation. This would include understanding what symptoms he or she is presenting and what treatment is being recommended and the possible consequences of either accepting or not accepting the recommended treatment, care or supervision.

(iii) What do "harm" and "deterioration" mean?

> "As a result of the mental disorder, the person is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre." s. 24(2)(a)(iii)

Harm

A person with a mental disorder in Saskatchewan does not have to be "dangerous" to qualify under this harm criterion. Dangerousness would be included as "harm" but the concept includes harms other than bodily harm. There are no court cases in Saskatchewan to provide guidance on interpreting "harm" but a BC Supreme Court Charter case stated that serious harms "can include harms that relate to the social, family, vocational or financial life of a patient as well as the patient's physical condition" (*McCorkell v. Riverview Hospital* [1993] B.C.J. No. 1518 at para. 58). Similarly, the Prince Edward Island Court of Appeal observed that their word "safety"

(comparable to "harm" in Saskatchewan) "includes things such as the alleviation of distressing physical, mental or psychiatric symptoms as well as the provision of creature comfort in appropriately congenial physical surroundings" (*Re Jenkins* [1984] P.E.I.J. No. 93, 5 D.L.R. (4th) 577 at 589 (P.E. I. C.A.). For example, a person with treatable manic symptoms who is not likely to cause bodily harm to themselves or others, but is in danger of being fired because of his outrageous behaviour at work and/or stressing his family with excessive spending and philandering could be considered to qualify for involuntary admission on the harm criterion.

How serious does the likely harm have to be?

The harm does not have to have actually occurred. Because of the mental disorder the person is "likely" to cause harm to themselves or others. The likely harm would have to be serious enough to justify hospitalization. The likely harm could not be trivial.

Deterioration

> "As a result of the mental disorder, the person is likely to cause harm to himself or herself or to others or to **suffer substantial mental or physical deterioration** if he or she is not detained in a mental health centre." s. 24(2)(a)(iii)

The deterioration criterion is an alternative to the harm criterion. A person who is not likely to harm themselves or others could still qualify for involuntary admission because he or she is found to be likely to suffer substantial mental or physical deterioration. "Deterioration" is not further defined in the *Act* but generally means that the person's symptoms or condition will get significantly worse without involuntary admission and treatment. Thus, the provision allows admission and treatment to begin to prevent the person from getting worse. This early intervention is likely to result in shorter hospital stays and less disruption to the person's life in the community. The deterioration criterion is also useful in renewal certificate situations and community treatment orders. In both situations, the person may have improved considerably with treatment and not be likely to cause harm. However, if the treatment is withdrawn through non-renewal of an inpatient or community order, the person will likely not continue with treatment and deteriorate significantly.

How far must the person be likely to deteriorate in order to reach the "substantial" threshold?

The general guide is that the physician would determine that without the admission and treatment, the person would probably deteriorate until they qualified for the harm criterion. However, the *MHSA* does not state that, and lesser deterioration may be acceptable as long as involuntary admission is required to prevent the deterioration.

What are the indicators of likely deterioration?

> Previous history of the course of an illness may show that the early signs of an episode are being repeated. Even without any history, a physician's knowledge about the course of an illness and the presentation in an individual, for example untreated early psychosis, may indicate the likelihood of substantial mental or physical deterioration.

13. Completing Form Gs

- Complete the identification information.
- Provide the grounds for the opinion in writing (legibly).
- If the patient is not in mental health centre, make conveyancing arrangements.
- Date and sign – both physician or resident and witness are required.

14. Renewal certificates – Form Gs

If the person is to be detained longer than the initial 21 days, a person "may be detained for successive periods of 21 days on the certificates (Form Gs), signed before the end of each 21-day period, of two physicians at least one of whom is a psychiatrist." (s. 24(8))

A resident may complete one renewal Form G as long as the other is completed by a psychiatrist and not completed by another resident or the resident's supervisor. Residents are defined as physicians for this section of the *Act*. (s. 24(1)(b))

The same criteria outlined above for Form G are used for renewal certificates.

15. Expiration or cancellation of Form G

If one Form G expires, the involuntary admission is terminated unless two new Form Gs are completed.

If the Form G expires, immediate notification of the patient is required:

> "the attending physician shall immediately cause the patient to be informed in writing that (a) the certificate or certificates have expired; and (b) he or she is no longer subject to detention or treatment pursuant to section 24." (s. 31.1)

Form L.3 is used for this purpose and for informing the nearest relative, proxy (if any), personal guardian (if any) and the official representative.

If the attending physician is of the opinion that the Form G criteria are no longer met, the person is discharged from involuntary status (may remain as a voluntary patient if the person wishes that and the physician agrees). The patient and official representative are informed using Form H.

Appendix 7

Peace Officer Responsibilities

Introduction

Police officers, or "peace officers" as they are referred to in *The Mental Health Services Act (MHSA)*, are defined in the *MHSA* as including:

> "(i) a member of the Royal Canadian Mounted Police;
> "(ii) a person appointed pursuant to *The Police Act, 1990* as a special constable or peace officer." s. 2(u) (New 2015)

Peace officers have a number of responsibilities under the *MHSA* as well as related responsibilities under common law and the Criminal Code of Canada. This appendix describes responsibilities and related actions under the *MHSA*, some of which may occur rarely, in the order they are most likely to be encountered.

Responsibilities: "Responsibilities" are actions of a peace officer (hereafter called "officer") that the *MHSA* or Criminal Code or common law require an officer to carry out or the law provides direct authority for the officer's actions (e.g. *MHSA* apprehensions).

Related actions: "Related actions", in this Guide, refers to actions an officer might take to help divert a person from the justice system to the health system where appropriate. For example, if an officer is called to deal with a domestic or street situation which appears to have a mental health element, they may choose to take the person involved for a mental health examination instead of in to detention. Related actions are within the officer's discretion under police policy governing that officer.

Approach to persons with mental illnesses: Neither the *MHSA* nor this Guide address how responsibilities for officers or staff are to be carried out. However, a considerate approach used with people under the *MHSA* is very important in helping avoid confrontation, encouraging health system involvement and reducing stigma towards the person. Police training information is helpful in addressing these issues.

List of potential involvement under *MHSA*

These items will be elaborated on below:

1. Voluntary admission
2. Physician or prescribed health professional examination
3. Peace officer apprehension (s. 20(1))

4. Judge warrant
5. Certificates by physicians with admitting privileges
6. Apprehension, conveyance and the use of reasonable force
7. Custody at the mental health centre
8. Unauthorized absence (s. 30)
9. Failure to comply with a Community Treatment Order
10. Assisting staff to keep the peace
11. Other apprehension and conveyance possibilities
    - Patients brought into or sent from Saskatchewan
    - Long term detention orders
    - Transfers from one mental health centre to another
    - Admission from courts

1. Voluntary admissions (s. 17)

Officers, like anyone trying to help, may recommend to a person that the person see a physician for help. Voluntary admission to a mental health centre (s. 17) can happen if the physician is willing to admit the person and the person consents. While it is preferred that the person seek voluntary help there are three options for starting the process for receiving service involuntarily if necessary: through a physician or prescribed professional (the preferred option) apprehension by an officer without a warrant or through a judge's warrant.

2. Physician or prescribed health professional examination (s. 18)

Under section 18 of the *MHSA*, a person may be seen by a physician or a prescribed health professional (approved nurse or resident) for an examination that may result in the person being taken involuntarily for another examination to determine if the person should be admitted.

- An officer, given the circumstance, may help persuade the person to be seen. The officer may provide relevant information to the physician for the examination.
- If the certificate (Form A) is signed:

  > "The certificate of a physician or prescribed health professional in the prescribed form [Form A] is sufficient authority to any person to apprehend the person who is the subject of the certificate and convey him or her immediately to the place where the examination is to be conducted by the physician who has admitting privileges to a mental health centre." (s. 18(3))

  Form A is sufficient authority for any person to apprehend and convey the person to the mental health centre for a psychiatric examination, although it is often an officer.

- If an officer is required to apprehend and convey as outlined above, a copy of the Form A is provided (usually by fax) to an officer's office and an officer is requested to come to where the individual is.
- The officer conveys the person to the place where the psychiatric examination is to take place, along with a copy of the Form A.
- The Form A should state the name of the physician with admitting privileges to a mental health centre with whom arrangements have been made for the examination.
- An officer, usually the conveying officer, is required to stay with the person until staff at the mental health centre take custody (see Custody at the mental health centre).
- The officer may also provide any relevant information, either verbally or in writing, to the physician with admitting privileges (e.g. about behaviour during conveyance). There is no specific form in which this information must be provided.
- If the person is not admitted following the examination, the officer may assist the person with arrangements to return home, but there is no obligation under the *MHSA* to do so.

3. Peace officer apprehensions (s. 20)

Section 20 of the *MHSA* provides officers with the authority, without a warrant, to apprehend a person with an apparent mental disorder who also meets other criteria (see below) and convey the person to a physician for an examination.

Amendments to peace officer powers (New 2015)

- The requirement that the person be "in a public place" has been deleted.
- The criteria of "causing a disturbance by acting in a manner that would normally be considered disorderly" has been deleted and replaced with a harm or deterioration criterion (see below). (s. 20(1)(b))

The amended procedures and criteria for the officer are:

> s. 20(1) "A peace officer may apprehend a person without a warrant and convey that person as soon as is reasonably practicable to a place where he or she may be examined by a physician if the peace officer has reasonable grounds to believe that the person is:
>
> (a) suffering from a mental disorder; and
>
> (b) likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre.

s. 20 (2) A person apprehended pursuant to subsection (1) must be examined by a physician as soon as is reasonably practicable and in all cases within 24 hours after his or her apprehension."

Procedures for the officer (s. 20)

Providing the s. 20 criteria are under consideration or met:

- Apprehension occurs without a warrant.
- Apprehension can occur on the basis of the officer's direct observation or information received (e.g. relatives, staff, etc.) so long as the officer has "reasonable grounds to believe."
- Apprehension can occur in a non-public place, without a warrant, unlike the previous *MHSA* requirement where the person had to be in a public place.
- An apprehended individual must be informed by the officer of the reasons for the apprehension. (s. 16)
- An apprehended individual must be conveyed to a physician so that the examination can take place as soon as is reasonable, but must happen within 24 hours of the apprehension. The place is usually a hospital but it could be to any physician anywhere.
- There is no form in the *MHSA* regulations for the officer to complete in making a s. 20 apprehension. However it is important that any relevant information be conveyed to the examining physician so that a decision whether to issue a certificate or not can be made. Forms developed by the police force and mental health centre can be helpful.
- Although not required in the *MHSA*, if the individual is not admitted, consider assisting them in making arrangements for return to their home.

Criteria used by the peace officer (s. 20)

The criteria for an officer to apprehend a person have changed and are now similar to those used by the physician. It is understood that officers are not physicians and are not held to the same standard, but they must have "reasonable grounds to believe" that the person has a mental disorder and is likely to cause harm to themselves or others OR is likely to suffer substantial mental or physical deterioration unless they are detained in a mental health centre (as an inpatient).

Reasonable grounds to believe that the person meets the criteria for apprehension by a peace officer may arise from information the officer observes and hears, and also information from other people. There are two criteria the officer must consider: mental disorder and being likely to cause harm or to suffer substantial mental or physical deterioration (s. 20(1)):

a. **Mental disorder.** The officer must have reasonable grounds to believe the person is suffering from a "mental disorder" defined as:

> "'Mental disorder' means a disorder of thought, perception, feelings or behaviour that seriously impairs a person's judgment, ability to recognize reality, ability to associate with others or ability to meet the ordinary demands of life, with respect to which treatment is advisable." (s. 2(j))

- This is a functional definition and does not require the officer to know what the diagnosis might be.
- Evidence for mental disorder may include one or more of disordered thoughts (e.g. illogical thinking, delusions), perceptions (e.g. hallucinations) or mood (e.g. depression, mania, flattened mood).
- Mental disorder symptoms must be serious enough to significantly impair judgment, recognition of reality, ability to associate with others or meet the ordinary demands of life.
- The officer must have a reasonable belief that treatment is advisable, but does not have to be sure. For the examples above, treatment is advisable.
- The officer may receive evidence from direct observation or conversation with the person and from other sources such as family or others who know the person or the person's past history.

b. **Harm or deterioration.** The officer must also have reasonable grounds to believe that the person with a mental disorder is likely to cause harm to himself or herself or others, or to suffer substantial mental or physical deterioration if not detained in a mental health centre.

Harm

A person with a mental disorder in Saskatchewan does not have to be "dangerous" to qualify under this harm criterion. Dangerousness would be included as a "harm" but the concept includes harms other than bodily harm. There are no court cases in Saskatchewan to provide guidance on interpreting "harm" but a BC Supreme Court Charter case stated that serious harms "can include harms that relate to the social, family, vocational or financial life of a patient as well as the patient's physical condition" (*McCorkell v. Riverview Hospital* [1993] B.C.J. No. 1518 at para. 58.). Similarly, the Prince Edward Island Court of Appeal observed that their word "safety" (comparable to "harm" in Saskatchewan) "includes things such as the alleviation of distressing physical, mental or psychiatric symptoms as well as the provision of creature comfort in appropriately congenial physical surroundings" ([1984]P.E.I.J. No. 93, 5 D.L.R. (4th) 577 at 589 (P.E. I. C.A.). For example, a person with treatable manic symptoms who is not likely to cause bodily harm but is in danger of being fired because of their outrageous behaviour at work, or stressing family

with excessive spending and philandering, could be considered to qualify for involuntary admission on the harm criterion.

How serious does the likely harm have to be?

The harm does not have to have actually occurred. Because of the mental disorder the person must be "likely" to cause harm to themselves or others. The likely harm would have to be serious enough to justify hospitalization. The likely harm could not be trivial.

Deterioration

> "The person with the mental disorder is "likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre." (s. 20(1)(b))

The deterioration criterion is an alternative to the harm criterion. A person who is not likely to harm themselves or others could still qualify for apprehension if the officer believes they are likely to suffer substantial mental or physical deterioration. "Deterioration" is not further defined in the *Act*, but generally means that the person's symptoms or condition will probably get significantly worse without involuntary admission and treatment.

What are the indicators of likely deterioration?

Previous history of the course of an illness may show that the early signs of an episode are being repeated. People who know the person may provide the officer with information on this.

4. Warrant from a judge (s. 19)

Where it is not possible for the person to have a voluntary examination by a physician, usually because they refuse to do so, and it is not appropriate to use the officer option, a judge may issue a warrant ordering that the person be apprehended and conveyed to a place where the person can undergo a psychiatric examination.

- The judge makes the decision on the basis of sworn evidence (Form B) (usually from a family member, but it could include evidence from mental health or other staff or an officer).
- The judge makes arrangements with a physician with admitting privileges in a mental health center and issues a warrant.
- Officers are commanded by the judge, through a "Warrant to Apprehend" (Form C) to "forthwith to apprehend" and convey the person to the place where the person will be examined.
- The officer stays with the person until the person can be examined or other arrangements are in place. If an officer does not remain with an individual until that individual can be examined, there is a risk that the person could leave without

being examined, as the authority to detain an individual pursuant to a section 20 apprehension, or pursuant to a judge's warrant, does not include the authority for that individual's detention to be transferred into the hands of hospital staff.

- The warrant may be exercised by someone other than an officer, who is named by the judge.

5. Apprehension and conveyance on certificates issued by a physician with admitting privileges (Form G)

Usually the person for whom an admission certificate has been issued (Form G) is in a mental health centre when the second certificate (Form G) is issued and officer involvement is not necessary. However, if the person is not in a mental health centre, s. 24(3) authorizes any person, to apprehend and convey the person to the mental health centre. This person is usually an officer requested by the physician.

6. Apprehension, conveyance and reasonable force

The *MHSA* requires officers to apprehend a person who may not want services and convey the person to a physician. The apprehension is not an arrest. Officers use persuasion and discretion in the amount of reasonable force needed for the apprehension.

Apprehension in a private dwelling: An officer may be asked to apprehend and convey a person who is in their own residence and refuses to come out even though there is a legitimate order for the officer to "apprehend and convey." This order can be made by a physician without warrant under the authority of the *MHSA* to "apprehend and convey" under Form A (s. 18), or Form G (s. 24), or return to the mental health centre from a community treatment order (s. 24.6(2)), or return to the mental health centre from unauthorized leave (s. 30). In addition, the officer may be required to exercise a warrant from a judge (s. 19) to apprehend and convey a person who has refused to leave their dwelling after reasonable attempts by the officer to persuade the person have failed.

Saskatchewan Government Police and Community Safety Services advises that even with an order or warrant issued pursuant to the *MHSA*, officers may only enter a dwelling house if permission to do so is obtained, or exigent circumstances (such as hot pursuit of the individual or the threat of imminent danger to self or others) exist.

7. Custody at the mental health centre

An officer who conveys the individual to the mental health centre on a Form A request, a s. 20 apprehension, or judge's warrant retains custody of the individual until the person can be examined or other arrangements are in place. If an officer does not remain with an individual until that individual can be examined, however, there is a risk that the person could leave without being examined, as the authority to detain an individual pursuant to a

s. 20 apprehension or pursuant to a judge's warrant does not include the authority for that individual's detention to be transferred into the hands of hospital staff.

Reducing wait times for peace officers and patients

Time spent waiting for an examination for both the officer and potential patient is recognized as an issue. The *MHSA* does not address this policy issue. Local areas have developed different approaches, all within the law, including by-passing the emergency department examinations and going directly to the Form G psychiatric examination. For example, Form A and Form C (Warrant to Apprehend, issued by a judge) require that arrangements have been made for the psychiatric examination prior to the individual arriving at the mental health centre. Under Canadian law, there is also no reason why a person apprehended by an officer under section 20 could not go directly for a Form G psychiatric examination. Hospital policy on the involvement of the emergency department may be relevant in addressing this issue. Forms can also be developed that will assist in conveying information from the officer to health staff who perform examinations.

8. Unauthorized absence s. 30

An officer may be requested by a physician at the mental health centre to return a person to the centre who has left the centre without authority. This includes a person who may be out of the mental health centre on a pass (s. 29) who fails to return on time or breaches a condition of the pass. A warrant or form is not needed; a telephone call is sufficient.

s. 30(1) "If a patient who is detained pursuant to section 24 leaves a mental health centre without having been discharged, the attending physician may, within 21 days after the patient's departure, if he or she considers it advisable to do so, order that the patient be returned to the mental health centre.

s. 30(2) If the attending physician orders that a patient be returned to a mental health centre pursuant to subsection (1), the patient may be apprehended and returned to the mental health centre, without a warrant, by:

(a) any peace officer; or

(b) any person designated by the attending physician."

9. Failure to comply with a Community Treatment Order (CTO)

"If a person who is the subject of a community treatment order fails to comply with the community treatment order and refuses to submit to a psychiatric examination… the attending physician or prescribed health professional may order that the person be apprehended and immediately conveyed to a place where the attending physician may examine the person." (s. 24.6(1))

Form H.7 "Order for the Apprehension, Conveyance and Examination of a Person", completed by the attending physician or prescribed health professional:

> "…is sufficient authority for any peace officer or other person named or described in the order to apprehend the person who is the subject of the order and immediately convey that person to a place where the psychiatrist may examine the person." (s. 24.6(2)(b))

A peace officer or other person directed to execute the order as specified on the order may execute this order.

10. Assisting staff to keep the peace

The *MHSA* does not explore dealing with actual or potential violence (keeping the peace). Hospitals have "codes" to provide additional staff help when untoward incidents happen, or are likely to happen. However, sometimes peace officer assistance is requested. Authority to assist staff in unsafe situations derive from the common law and duties under the *Police Act* (s. 36(2)) which give the officer the:

> "power and the responsibility to:
> (a) perform all duties that are assigned to constables or peace officers in relation to:
> (i) the preservation of peace…"

An officer may be called upon to assist when there is violence or a threat of violence and staff resources are not able to deal with the situation.

An officer may also be requested to assist in restraining a patient to give an injection. Since the reason for the request is to prevent injuries to the patient or the staff if the officer did not provide assistance, that request would be for the preservation of peace.

The logic for officers to respond to a request to assist staff in giving an injection is this: the patient may be doing well because the physician has made a legitimate order to give the patient the medication without consent under s. 25. The nurse attempts to follow that legitimate order but the patient refuses to take the injection. The only way the medication can be given is if done so by forcibly restraining the patient. The patient could resist and assault a nurse and the patient may also be injured unless there is extra support. If the nurse is of the opinion that the hospital support team is insufficient to give the injection without the likelihood of a breach of the peace (i.e. staff and patient being injured), then it is legitimate for an officer to lend support. Workers compensation rules also align with this position. Often the extra presence of an officer is sufficient for the patient to take the injection without resistance. If the officer did not assist, it is likely that a staff would be injured and the patient could be charged with assault, may be tried in court, and could be sent to the forensic psychiatric system.

11. Other apprehension and conveyance possibilities

Uncommon requests for officer assistance in apprehending and conveying people could occur under the following sections:

Patients brought into or sent from Saskatchewan

- Form D, completed by the provincial director of mental health, authorizes an officer to take a person from another jurisdiction into custody and convey them to a named mental health centre. (s. 21)
- Form L. 2 (s. 28) is completed by the provincial director to return an involuntary patient to another jurisdiction. Officer assistance may be required.

Transfers from one mental health centre to another

- Patients can be transferred from one mental health centre to another. It is highly unlikely that peace officer assistance would be needed, but a possibility. (s. 28) Typically, transfers of this nature are done by ambulance.

Long term detention orders

- An officer may be requested to assist in conveying a person currently in a mental health centre who has been issued a long term detention order to another mental health facility. (s. 24.1) Typically this is done by ambulance or staff and/or security.

Admission from courts or corrections

- An officer may be ordered by a judge, on Form E "Order to Convey in Custody for Voluntary Examination" to convey to a mental health centre a person charged with an offence who requests a psychiatric examination. (s. 22(2)) An officer may also be required to convey when a judge completes Form F "Order for Psychiatric Examination as an Outpatient." (s.22(3))

An officer may be involved in conveyance to a mental health centre of a person under the mental disorder sections of the Criminal Code or on an order of the Commissioner of the Correctional Service of Canada in the transfer of a person from a penitentiary to a mental health centre. (s. 23)

Appendix 8

Community Treatment Orders

This appendix discusses the following information:

1. Purpose of a Community Treatment Order
2. How CTOs work
3. Criteria for a CTO to be issued
4. CTO services
5. Issuing the CTO: (two psychiatrist examinations)
6. Renewing the CTO (one psychiatrist) (New 2015)
7. Treatment planning and authorization under a CTO
8. Duty to provide care and treatment to remove the CTO
9. Notification of CTO issuance and provision copies
10. Notification if CTO not renewed or canceled
11. Non Compliance with the CTO (Form H.7)
12. Options on recall
13. Appeals to the review panel: voluntary and mandatory
14. Leaving the province

1. Purpose of a Community Treatment Order

The purpose of a community treatment order (CTO) is not explicitly stated in *The Mental Health Services Act (MHSA)*. CTOs are viewed as useful for people who need treatment, care and supervision in the community to stay well and avoid relapses and hospitalization, but who do not voluntarily comply with their treatment plan. "In the community" means outside a mental health centre (inpatient unit). (s. 24.2(1))

2. How CTOs work

A person who meets the criteria for a CTO is provided with a treatment plan, usually including medication and regular reviews of progress. The CTO requires the person to comply with the treatment plan but it also requires mental health staff to follow up with people rather than not following up when they do not attend appointments. These requirements help people adhere to the treatment plan. If the person does not comply with the terms of the CTO, they can be hospitalized. Many people would prefer living in the community even with the conditions of the CTO rather than being detained in hospital. This is an incentive for the person to comply with the treatment plan.

3. Criteria for a CTO to be issued

For a CTO to be issued, a psychiatrist must conduct an examination and determine that all the criteria for a CTO are met. A second psychiatrist must then conduct an independent examination and agree with the assessment and service plan laid out by the first examining psychiatrist. This is called a "validation certificate" or certificate in support of a CTO.

For a CTO to be issued the following criteria must all be met:

24.3(1) "A community treatment order must:

(a) state that the psychiatrist has examined the person named in the community treatment order within the immediately preceding 72 hours and that, on the basis of the examination and any other pertinent facts regarding the person or the person's condition that have been communicated to the psychiatrist, the psychiatrist has probable cause to believe that:

(i) the person is suffering from a mental disorder for which he or she is in need of treatment or care and supervision in the community and that the treatment and care can be provided in the community;

(ii) during the preceding two year period, the person:
- (A) has been admitted to a mental health centre, voluntarily or involuntarily, on at least one occasion (New 2015); or
- (B) has previously been the subject of a community treatment order.

(iii) if the person does not receive treatment or care and supervision while residing in the community, the person is likely to cause harm to himself or herself or to others, or to suffer substantial mental or physical deterioration, as a result of the mental disorder;

(iv) the services that the person requires in order to reside in the community so that the person will not be likely to cause harm to himself or herself or to others, or to suffer substantial mental or physical deterioration:
- (A) exist in the community;
- (B) are available to the person; and
- (C) will be provided to the person;

(v) as a result of the mental disorder, the person is unable to fully understand and to make an informed decision regarding his or her need for treatment or care and supervision; and

(vi) the person is capable of complying with the requirements for treatment or care and supervision contained in the treatment order;

(b) state the facts on which the psychiatrist has formed his or her opinion that the person meets the criteria set out in clause (a); [Form H.3, Form H.4 for validating psychiatrist].

Comment on the CTO Criteria (s. 24.3)(1)(a))

All criteria must be met.

(i) Mental disorder, in need of treatment which can be provided in the community

The mental disorder (definition is the same as for an inpatient s. 2(j)) must be severe enough to warrant compulsory treatment, care or supervision in the community.

(ii) Previous hospitalization (New 2015)

The person must have had at least one admission to hospital in the previous two years (New 2015). The admission can be voluntary or involuntary. This means that the person could be put on a CTO on being discharged from their first admission. This may be helpful for some people having their first psychotic episode. Usually people on CTOs have had multiple admissions because they go off their treatment plan once back in the community. As long as the person has had one admission, they could be put on the CTO at any time while in the community during the next two years (prior to the amendments the previous hospitalization requirement was three admissions, or 60 days in hospital in the previous two years).

(iii) Harm/deterioration

The person must either be "likely to cause harm to him or herself or others" or likely to "suffer substantial mental or physical deterioration" if not provided with community services.

The deterioration criterion is particularly important for CTOs, since with treatment, many people on a CTO would not meet the "likely to cause harm" criterion. However, if it is likely that without the CTO the person would stop treatment and deteriorate, potentially relapsing and being rehospitalized, this person would fit the deterioration criterion.

(iv) Services must be available

The services specified for the person to live in the community, and not be likely to cause harm or deterioration, must be provided. If not, the person cannot be put on a CTO. This criterion should help prevent using CTOs for inappropriate discharges from hospital where there are insufficient services for that person. However, that does not prevent discharge without a CTO due to inadequate community service situations.

(v) Not fully capable of making a treatment decision

This is the same "capability" criterion as for involuntary inpatients. If a person is able to fully understand and make an informed decision regarding the CTO (e.g. need for it, various components of it, consequences of no CTO) they cannot be put on a CTO. The basis for this is that if a person who is considered fully capable of making these decisions chooses not to voluntarily receive recommended services and subsequently relapse, that is considered their fault and they suffer the consequences. However, as

with involuntary inpatients the level of capability is set high at "fully" because the consequences of refusal can be devastating.

(vi) Capable of complying with the CTO requirements

The person must be physically and mentally "capable", with help if needed and available, of complying with the conditions in the CTO. The person may not want to comply and indeed may not, but that does not preclude them from being put on a CTO.

4. CTO Services

As part of the CTO certificate, the psychiatrist must describe the services in the community the person will be provided with.

Section 24.3(1):

> "(c) describe the services that will be provided to the person and the treatment that is recommended for the person;
>
> (d) state that the person is to submit to the medical treatment that is prescribed by the attending physician and is to attend appointments with the attending physician or with the responsible individuals identified pursuant to clause (e) in the places as scheduled, from time to time, consistent with good medical practice;
>
> (d.1) if considered necessary, state that the person is required to stay at a residence specified by the psychiatrist; (New 2015)
>
> (e) identify the names of the persons authorized by the regional director who will ensure that the person who is the subject of the community treatment order will receive the services that he or she requires in order to be able to reside in the community."

Comment on CTO Service provisions

(c) Services and treatment

Form H.3 "Community Treatment Order" where the psychiatrist specifies the reasonable grounds that the person meets the criteria for the CTO, is also used to specify the services. Form H.3 states:

> "and therefore [after meeting the CTO criteria] he or she will be provided with the following services and treatments…"

The services specified in the CTO are compulsory services that the person must comply with. A person living in the community may need the incentive of a CTO to comply with a service or treatment that is necessary but they do not want to comply with. That specification would be outlined in the CTO. However, there may be other aspects of the treatment plan that are desirable, or even necessary, that the person is quite willing to comply with. These voluntarily accepted services do not need to be in the

CTO. A comprehensive community plan may contain some elements that are in the CTO and some elements that are not. It is only the treatment or care and supervision requirements specified in the CTO that can be enforced through recall to hospital if the person does not comply with the CTO condition.

(d) Medical treatments and appointments

This is a direction to the patient that they must submit to medical treatments and appointments, at times and places specified, with the attending physician or other responsible individuals such as nurses. The medical treatments are specified in the treatment description under (c).

(d.1) Residence (New 2015)

Sometimes it is considered necessary for a CTO to specify where the person will live. While this decision is usually made by the treatment team and taking the patient's views into account, the *MHSA* requires that the psychiatrist signs the order and therefore the psychiatrist must agree with any residence information included. If considered necessary, the CTO may state that the person is required to stay at a residence specified on the order. The residence must be at a specified address but can be changed by the psychiatrist without having to write a new CTO. If the person must move to another residence for reasons beyond their control, they should provide prompt notice of the circumstances to the attending physician or the person authorized to supervise the CTO by the regional director as specified on the CTO. If the residence must change, the attending physician or person authorized to supervise the CTO by the regional director as specified on the CTO could make a notation in the file without having to go through the process of issuing a new CTO.

(e) Authorized staff to supervise the CTO

While any staff or other person can be involved with the care and treatment of a person on a CTO, the names of those authorized to ensure that a person on a CTO will receive the services they need must be recorded on the CTO. These people will have been authorized by the regional director of mental health. If the authorized person is unavailable (due to vacation leave, sick leave or otherwise), a cover worker for that authorized person can act in the authorized person's place in ensuring that the person subject of the CTO will receive the services that they require without having to go through the process of issuing a new CTO.

5. Issuing the CTO (two psychiatrist examinations)

Form H.3 "Community Treatment Order" is completed and signed by the first examining psychiatrist. A copy of Form H.3 is provided to the psychiatrist who will conduct the second independent examination to validate the first CTO.

The second psychiatrist's examination is to validate the first and issue Form H.4 "Certificate in Support of a Community Treatment Order". (Form H.4) (s. 24.4(1)(a)) Form H.4 must confirm that the criteria for the CTO have been met including agreeing with the treatment plan. (s. 24.4(1)(b)(c)(d))

If a second psychiatrist is not available, Form H.4 may be completed by a physician appointed by the regional director (s. 24.31). However, such a certificate is only valid for 72 hours from the issuance of the Community Treatment Order (Form H.3). (s. 24.5(1.1)) If a psychiatrist has not issued another "Certificate in Support of a Community Treatment Order" (Form H.4) in that time, the CTO lapses and the process must be repeated. It is suggested that where possible a second psychiatrist be found within the three days since three examinations within a short period may be onerous for the person.

6. Renewing the CTO (one psychiatrist) (New 2015)

Renewal examinations for the continuation of the CTO, if warranted, must take place prior to the expiration date of the CTO (at maximum is six months after the first CTO certificate was issued). Although the initial CTO requires two psychiatrists, renewals of the CTO require only one (New 2015). The renewal is completed through the same process as for a "Certificate in Support of a Community Treatment Order," as outlined above. If the CTO has expired, two new certificates are required.

Where a psychiatrist is not available to complete a renewal certificate, a physician appointed by the regional director of mental health may do so. However, that CTO is only valid for 72 hours unless the patient is examined by a psychiatrist before that 72 hours expires, which then allows the CTO to expire after the date specified on the CTO. (s. 24.5(1.2)) (New 2015)

How long can the CTO be issued for? **(New 2015)**

A CTO can now be issued for up to 6 months. The first psychiatrist who issued the Form H.3 specifies when the CTO lapses. That can be any time up to six months (s. 24.5).

What if the person refuses to be examined for a CTO or CTO renewal?

If a CTO has been issued by a psychiatrist and the person refuses to have a validation examination or renewal examination, the psychiatrist can order the person to submit to an examination by a second psychiatrist or an authorized physician. The authorized physician's certificate is only valid for 72 hours and a psychiatrist's certificate is required to continue the CTO. If the person continues to refuse, the psychiatrist can have the person apprehended and taken to a place for validating or extending the CTO. (s. 24.3(4))

7. Treatment planning and authorization under a CTO

The treatment plan approved by the issuing and validating psychiatrist of the CTO is a required component of the CTO (see above "Comment on CTO Service Provisions"). Although the patient must be capable of complying with the CTO, the patient does not consent to the CTO treatment or requirements. (s. 25) This is because the patient, as part of the CTO criterion, has been found to be "unable to fully understand and to make an informed decision regarding his or her need for treatment or care and supervision." (s. 24.3(1)((a)(v))

The attending physician authorizes the treatment and conditions of the CTO in the same manner as an attending physician does for involuntary inpatients. (s. 25) The physician has an obligation (see below, s. 24.7) to choose the most effective treatment, even if the patient does not agree. However, the patient's views must be taken into account depending on the patient's medical condition (s. 25(3)) and, where appropriate, the views of people who know the patient should be considered as well. A community treatment plan will often address more than just the CTO requirements. The comprehensive service plan may also address rehabilitation, residential, educational, recreational, non *MHSA* medical needs and other recovery services that the person agrees to. These, together with the CTO services, will provide a comprehensive plan to aid recovery.

8. Duty to provide care and treatment in order to remove the CTO

The *MHSA* puts an obligation on the attending physician (and, by implication, those working with the physician):

> "… the attending physician shall endeavour, with all resources reasonably available in the community, to provide the person who is the subject of the order with services so that the compulsory treatment or care and supervision of the person will no longer be required." (s. 24.7)

9. Notification of CTO issuance and provision of copies

> "Where a community treatment order has been validated [by a second certificate], the attending physician shall provide a copy of it to:
>
> (a) the patient;
>
> (b) the patient's nearest relative;
>
> (b.1) the patient's proxy, if any (New 2015)
>
> (b.2) the patient's personal guardian, if any (New 2015)
>
> (c) an official representative for the region." (s. 24.3(3))

10. Notification if CTO not renewed or cancelled

If the CTO expires and is not renewed, the patient must be notified using Form H.5 "Notification by an Attending Physician Advising a Patient that a Community Treatment Order is No Longer in Effect." (s. 24.5(2)) Form H.5 is sent to the patient, nearest relative, any proxy, any personal guardian and the official representative.

When the attending physician determines that a person on a CTO no longer meets the CTO criteria, Form H.6 "Order to Revoke a Community Treatment Order" is distributed to the patient, nearest relative, proxy (if any), personal guardian (if any) and the official representative. (s. 24.5(3))

11. Non Compliance with the CTO (Form H.7)

A peace officer or another person directed to execute the order may be ordered by the attending physician to apprehend and convey a person for a psychiatric examination who does not comply with the CTO. If the attending physician is not available a prescribed health professional may complete Form H.7 (New 2015).

> "If a person who is the subject of a community treatment order fails to comply with the community treatment order and refuses to submit to a psychiatric examination to ascertain whether or not he or she should be admitted to a mental health centre pursuant to section 24, the attending physician or prescribed health professional [New 2015] may order that the person be apprehended and immediately conveyed to a place where the attending physician may examine the person.
>
> (2) An order issued pursuant to subsection (1):
>
> (a) is to be in the prescribed form [Form H.7 Order for the Apprehension, Conveyance and Examination of a Person]; and
>
> (b) is sufficient authority for any peace officer or other person named or described in the order to apprehend the person who is the subject of the order and immediately convey that person to a place where the psychiatrist may examine the person." (s. 24.6(1) and (2))

12. Options on recall

On being conveyed to the hospital there are the following options:

1. Typically if patients are not compliant with their medication(s) that are part of the CTO treatment plan, they are conveyed to the emergency department for administration of the medication. They are also assessed by a psychiatrist to determine if they require admission or if they can be returned home.

2. Admit the person on one Form G for up to 72 hours with the assumption that the person would likely settle in that period. A second Form G could be completed if a longer period was required.

13. Appeals to the review panel: voluntary and mandatory

The review panel may only hear an appeal of the decision to issue or renew a CTO. The review panel may not hear an appeal or complaint against the CTO requirements. The procedures on assistance from the official representative, timing of appeals, evidence and procedures are the same as for involuntary inpatients and are addressed in **Chapter 6: Appeal and Review Procedures** and in **Appendix 9: Review Panel and Official Representative Procedures**.

(i) Voluntary appeals
A request to the review panel appealing against a CTO may be made by the patient or on the patient's behalf by the official representative, or a nearest relative, proxy or personal guardian. Voluntary appeals may be made at any time 21 days after a previous review, which includes mandatory reviews. (s. 34(4.1)(b))

(ii) Mandatory appeals
Even if the patient does not appeal or does not want an appeal, section 34(5.2) states that if the CTO extends beyond six months because there is a renewal:

> "the attending physician shall notify the chairperson of the review panel for the region of the extension and, for the purposes of section 34, that notice is deemed to be an appeal by the person who is subject to the community treatment order."

However, there is no right of appeal when an appeal of the decision at issue has been considered by the review panel in the preceding 21 days. (s. 34(5.1)) Therefore, after the mandatory six month review, a voluntary appeal could not be launched until 21 days had elapsed.

14. Leaving the province

If a patient leaves the province, the CTO has no effect in another jurisdiction. If the person returned to Saskatchewan during the period the CTO was written for, it would then be valid. However, if the person becomes involved with the mental health system in another jurisdiction, the patients brought into or sent from Saskatchewan sections (s. 21, s. 28.2) discussed above may apply.

Appendix 9

Review Panel and Official Representative Procedures

This appendix will discuss the following:

1. Review panel and official representative responsibilities
2. What can and cannot be appealed?
3. How are the patient and others informed about the review panel?
4. Official representative's role in providing information about the review panel
5. Who may apply to the review panel for an appeal?
6. How is an application made to the review panel?
7. Who does the review panel chair inform about the review?
8. Where does the hearing take place?
9. How is the review conducted?
10. What is the review panel's decision making process?
11. When and how is the decision communicated?
12. Can an appeal be made against a review panel decision?
13. Frequency of voluntary and deemed (automatic) appeals to the review panel
14. Official representative: additional responsibilities

1. Review panel and official representative responsibilities

The Mental Health Services Act (MHSA) provides for review panels and official representatives to help ensure that certain rights and provisions related to involuntary patients are known by the patient and their family and addressed.

A review panel makes decisions where an involuntary patient or someone on their behalf appeals against involuntary detention, a community treatment order, a transfer or electroconvulsive treatment (ECT). Review panel members are appointed by the minister and each panel consists of a lawyer, usually as chair, a physician and a member of the public with an interest in mental health,

The official representative (usually a lawyer, appointed by the minister) assists involuntary patients in understanding their rights and obligations and, if asked, helps the patient with the review panel process. The minister can appoint a law partnership as an official representative. Although an official representative is appointed to a specific region, they can also serve in other regions if needed. The official representative has a number of other responsibilities, discussed below.

2. What can and cannot be appealed?

An appeal can be made by an involuntary patient for the following:

- Detention under one or two Form Gs (either initial or renewal);
- A validated community treatment order (CTO);
- Transfer to another mental health centre; and
- An order for electroconvulsive therapy (ECT)

Other requirements or treatments an involuntary patient may not agree with cannot be appealed to the review panel but may be discussed with the treating physician or mental health centre administration.

3. How are the patient and others informed about the review panel?

The attending physician provides Form M "Notification Regarding Appeal Procedures" to the patient, the nearest relative or proxy or guardian (if any) and to the official representative when the person becomes an involuntary patient (after the first Form G is completed). Form M provides information on the right of appeal and the name and address of the chairperson of the review panel.

Form M is also sent to the same people if the patient has been issued a CTO or ordered to be transferred to another mental health centre.

If the patient objects to the nearest relative being informed because it would endanger the patient's health or safety or be an unreasonable invasion of privacy, the attending physician, after consulting with the official representative, may withhold the information and make a record of the reasons for this. (s. 33(3) to (5))

For an appeal against proposed ECT, Form J "Notification Regarding Appeal Procedures" (see list of forms) is sent to the same people.

4. Official representative's role in providing information about the review panel

In addition to the patient receiving written information on Form M, the official representative on receiving Form M shall:

> "(a) visit the patient;
>
> "(b) as soon as is reasonably practicable, advise the patient about his or her right of appeal; and
>
> "(c) provide any assistance that the official representative considers necessary to enable the patient, or a nearest relative, proxy or personal guardian on the patient's behalf, to initiate an appeal." (s. 33(2))

Regulation 13 provides more information on the duties of the official representative.

5. Who may apply to the review panel for an appeal?

The patient may apply directly to the review panel or ask the official representative for assistance to do so. The appeal may be requested also by the nearest relative, proxy or guardian or "any other person who has a sufficient interest may submit an appeal." (s. 34(3))

The official representative who assists the patient or others to initiate the appeal shall:

> "(c) provide any assistance that the official representative considers necessary to enable the patient or a nearest relative, proxy or personal guardian on the patient's behalf, to initiate an appeal." (s. 33(2)(c))

If the patient does not want to apply to the review panel but another person does, the official representative, while providing information to both, may consider "representing" the other person as a conflict of interest. (See Regulation 13)

6. How is an application made to the review panel?

The patient or anyone on their behalf, often the official representative, can make an application to the review panel by filling out Form N "Appeal to Review Panel". The request for an appeal, Form N, can be provided to the chairperson via fax, courier or by a telephone call from the mental health centre. The name, address and phone number of the review panel chair are on Form M, by which the person was notified of the review panel's function.

7. Who does the review panel chair inform about the review?

When the review panel chairperson receives an appeal he or she notifies the mental health centre "without delay." (Regulation 19(2)) The attending physician of a person appealing their CTO is informed "immediately." (Regulation 19(3)) In addition the chairperson shall:

> "(a) provide notification of the time and place of the hearing to the appellant [patient]
>
> "(a.1) make every reasonable effort to provide notification of the time and place of the hearing to:
>
> (i) the person who submitted the appeal, if other than the appellant;
>
> (ii) the official representative for the region;
>
> (iii) the officer charge of the mental health centre in which the appellant is a patient;
>
> (iv) the chief psychiatrist of the mental health centre mentioned in subclause (iii);
>
> (v) the attending physician." (Regulation 21(1))

8. Where does the hearing take place?

The hearing is usually at the mental health centre. With the permission of the chairperson, people with information to contribute may be involved through the telephone.

9. How is the review conducted?

The review panel considers written information and conducts a hearing to elicit facts and evidence. The *MHSA* states at section 34(6):

> "the review panel shall:
>
> (a) immediately carry out any investigation that it considers necessary to speedily determine the validity of the appeal; and
>
> (b) invite the appellant and other persons considered by the review panel to be affected by the appeal to testify or produce evidence relating to the appeal."

Written material includes Form O "Statement by Attending Physician to Review Panel". A Form O is completed by the attending physician and any other material requested. Form O requires copies of the relevant certificates: "certificate/certificates under which the patient is currently being detained" a transfer order or "community treatment order" the "certificate in support of a community treatment order" and "portions of the clinical record of the patient that are pertinent to the appeal." The mental health centre chart is also available for review by members of the review panel.

- The hearing is convened with all interested parties in attendance including the patient, psychiatrist and review panel members. The inpatient nurse and outpatient case worker are also eligible to attend if they have something to contribute. Friends and family may attend with the approval of the chairperson.
- The hearing is informal and the review panel "is not bound by the rules of law concerning evidence and may accept any evidence that the review panel considers appropriate." (Regulation 23)
- The patient can see any written evidence, be personally present during oral evidence, present evidence, cross examine and be represented by counsel. Usually the patient requests the official representative to assist them at the hearing. The person can be represented by legal counsel. (s. 34(7))
- Evidence may be provided to the hearing by telephone as long as all parties can hear the conversation and the chairperson approves.
- The hearing is private, but the chairperson may admit others for legitimate purposes.

10. What is the review panel's decision making process?

- Based on the written and oral information, the review panel determines whether or not the criteria for the certificate have been reasonably met on the date of the hearing. They do not consider whether or not the certificate was initially warranted when first issued. The review panel must ask itself if there is a reasonable factual basis to meet the criteria set forth in the certificate whether for admission, CTO, transfer or ECT.
- In considering if the patient currently meets the involuntary criteria, the review panel uses the section 24 criteria. (Discussed in **Appendix 6: Completing Form G: Certificate of Medical Practitioners for Compulsory Admission of a Person to a Mental Health Centre**)
- Although a person under a CTO is functioning well, they may continue to meet the CTO criteria because they are "likely… to suffer substantial mental or physical deterioration" and this person is likely to stop taking their treatment if the CTO is cancelled. (See **Appendix 8: Community Treatment Orders**)
- The decision of the review panel is by consensus or by majority vote of members present.

11. When and how is the decision communicated?

The gathering of evidence, the hearing and the written report must all be completed and transmitted:

> "before the end of the third business day following the day the appeal was received." (s. 34(9))

That means that if the appeal was received in the review panel office on Tuesday, the report would have to be completed and transmitted by midnight on the following Friday. Saturday, Sunday and holidays are not included in the three business days' time limit. (s. 2(b)) The review panel chair may also verbally inform the patient of the decision shortly after the hearing.

The written report of the decision is transmitted to:

(a) the appellant [patient];

(b) the nearest relative, if he or she submitted the appeal;

(c) the proxy, if any;

(d) the personal guardian, if any;

(e) an official representative for the region, if he or she submitted the appeal; and

(f) the officer in charge of the mental health centre in which the a appellant is a patient. (s. 34(9))

12. Can an appeal be made against a review panel decision?

Yes, but only the patient or someone on his or her behalf can appeal the decision not to grant the patient's appeal. The mental health centre or someone opposing the decision to rescind the certificate or order made by a review panel cannot appeal the decision.

The appeal is made to the Court of Queen's Bench within 30 days of the date of the review panel's decision. The appeal continues even though a certificate or CTO lapses. Notice is served on the parties. An affidavit setting out the facts in support of the patient's appeal is required and the court may direct further evidence. There is no appeal of the decision of the court. (s. 36)

13. Frequency of voluntary and deemed (automatic) appeals to the review panel

Voluntary appeals

For patients admitted under section 24 (two Form Gs), one voluntary appeal to the review panel is allowed for the 21 day period during which the certificates are valid. For each extension of 21 days, one voluntary appeal is allowed.

Patients on a CTO are allowed a voluntary appeal to the review panel when "(a) a new community treatment order is written with respect to the person or (b) more than 21 days have elapsed since a decision was made by the review panel concerning a community treatment order that is still in effect." (s. 34(4.1)

Deemed (automatic) appeals (s. 34)

(a) Involuntary inpatient. As long as an involuntary inpatient has not made a voluntary appeal to the review panel in the previous 21 days, the review panel must conduct a review even if the patient says he or she does not want a review in the following timeframes:

For patients on their first set of s. 24 Form G certificates, if new Form G certificates are issued authorizing the detention of the person for a period extending beyond the initial 21 days, the attending physician notifies the chairperson of the review panel and that notice is "deemed to be an appeal by the person being detained." (s. 34(4.1)(5)) Deemed or mandatory appeals then occur thereafter at six monthly intervals. There is no deemed appeal if the person has had a voluntary appeal within the past 21 days.

(b) CTO. For patients on a CTO, the deemed appeal is required every six months. Again there is no deemed appeal if a voluntary appeal has occurred within the past 21 days.

14. Official representative: additional responsibilities

All of the official representative's duties are described in Regulations 13.

The official representative may:

- make any contact that he or she considers necessary to advise a person "concerning his or her rights and obligations in relation to apprehension or detention" who has been apprehended or detained under sections 18 (Form A), 19 (judge), 21 (brought into Saskatchewan), 22 (charged with offence), 23.1 (Criminal Code mental health) or 24.6 (non-compliant CTO) of the *Act*;
- visit a patient as soon as practicable following detention under s.23 (corrections or Criminal Code);
- for an involuntary patient admitted under s. 24 (Form G), the official representative must visit the patient within 24 hours of detention "to provide information concerning the rights and obligations of the patient in relation to the detention, and to offer assistance to enable the patient to exercise his or her rights";
- visit a patient as soon as practicable where an application has been made for a long term detention order under s. 24.1 and assist that patient to initiate a review if requested;
- speak with a person as soon as practicable after a CTO comes into effect and provide information on rights and obligations and offer assistance to enable the person to exercise his or her rights;
- visit a patient as soon as practicable, before transfer, where a transfer is ordered under s.28 from one inpatient facility to another in a different municipality or where a person is to be transferred out of the province;
- receive copies of the orders, warrants and/or certificates issued pursuant to sections 18, 19, 21, 22, 23, 24 and 28;
- receive a copy of an order revoking section 24.1(3) long-term detention orders;
- receive a copy of a report from the chairperson of the review panel decision regarding detention or transfer;
- visit a person as soon as practicable before transfer out of province under s.28.2;
- visit a patient as soon as practicable and in any event except in case of emergency prior to administration of involuntary ECT, where this is ordered in accordance with regulations;
- visit any other inpatient or outpatient on request;
- assist a person who is entitled to appeal to a review panel by submitting an appeal, assisting him or her in obtaining counsel, if requested, attending and representing him or her at the hearing; and
- assist a person who is entitled to appeal a review panel decision to the Court of Queen's Bench to submit an appeal and obtain legal counsel.

Appendix 10

Collection, Use and Disclosure of Personal Health Information

Introduction

This appendix addresses the collection, use and disclosure of personal health information for persons receiving health services including services under *The Mental Health Services Act (MHSA)*. The following issues will be reviewed:

1. Confidentiality provisions transferred from *MHSA* to *The Health Information Protection Act (HIPA)*
2. What is *HIPA*?
3. Why information provisions were transferred from *MHSA* to *HIPA*?
4. How *HIPA* works: key concepts (overview, terminology)
5. Collecting personal health information under *HIPA*
6. Use of personal health information under *HIPA*
7. Disclosure of personal health information under *HIPA*
8. Case scenarios (adult, child): Applying *HIPA* in mental health settings
9. Other *HIPA* issues: accessing and correcting one's personal health information; appeals
10. Getting help on *HIPA* issues
11. Other requests for information (e.g. police, insurance companies)
12. *HIPA* functions in the private health services field

You should work with your organization's privacy officer to properly integrate practices with current policies.

1. Confidential provisions transferred from *MHSA* to *HIPA*

Section 38 and Regulations 15-18 of the *MHSA*, the confidentiality and disclosure of information provisions, have been removed from the *MHSA*. The only disclosure provision remaining in the *MHSA* is Regulation 15(2) for providing personal health information to the review panel without consent and those relating to mental health approved homes. All other personal health information functions are now subject to the provisions of *HIPA*.

2. What is *HIPA*?

HIPA is designed to "improve the privacy of people's personal health information while ensuring adequate sharing of personal health information is possible to provide health services" (page 2 ***An Overview of The Health Information Protection Act, Saskatchewan Health***, August 2003).

HIPA controls personal health information in most health services, however, health information collected during the course of services provided under the *MHSA* was specifically excluded from *HIPA* until the 2015 amendments to the *MHSA* (Bill 127).

3. Why information provisions were transferred from *MHSA* to *HIPA*?

MHSA confidentiality clauses were passed in 1985 and *HIPA* not until 2003.

In Mental Health and Addictions Services, staff had to work within the confidentiality provisions in the *MHSA* for a patient's mental health challenges, and within the confidentiality provisions in *HIPA* for their addiction issues.

To reduce stigma and promote efficiency, mental health service information sharing should be treated like all other health services. The Ministry of Health therefore concluded that it would be clearer for staff and more beneficial to patients to have one set of rules.

4. How *HIPA* works: key concepts

***HIPA* Overview** (Note: all section references refer to *HIPA*.)

When staff of an organization (called a "trustee") collect personal health information to address a person's health challenges they must have consent and obtain the information directly from the person unless this is not reasonable. The trustee must treat the information in confidence except if there is express consent, implied consent, deemed consent or an authority under *HIPA* to use it or disclose it without consent. The personal health information collected must only be used or disclosed on a "need to know" basis.

***HIPA* Terminology** (note: a *HIPA* glossary is at http://www.oipc.sk.ca/Resources/HIPA%20Glossary%20-%20Blue%20Box.pdf)

"Trustee," "personal health information," "need to know," "express consent," "implied consent," "deemed consent," and "without consent" are important concepts in *HIPA*.

"Trustee" *HIPA* applies to individuals who and organizations that are part of Saskatchewan's health system and have custody and control of personal health information. The *Act* calls them **trustees**, to reflect the fact that they hold personal health information "in trust" and must manage and protect the information with the best interests of the individual in mind.

- **Trustees include:** government institutions (e.g. Saskatchewan Health); regional health authorities and affiliates (this includes hospitals and all health facilities operated by a health region); special care homes; personal care homes; mental health facilities; health facilities licensed under *The Health Facilities Licensing Act*; laboratories; pharmacies, regulated professionals. (see s. 2 of *HIPA* for full list)

"Personal Health Information" Personal health information means:

(i) information with respect to the physical or mental health of the individual;

(ii) information with respect to any health service provided to the individual, donation of body parts or substances or test results. (see s. 2 for full list)

"Need to Know" "A trustee shall collect, use or disclose only the personal health information that is reasonably necessary for the purpose for which it is being collected, used or disclosed." (s. 23(1))

"Consent – express, implied, deemed" Consent must relate to the purposes for which the information is required; be informed; be given voluntarily and not be obtained through misrepresentation, fraud or coercion. (s. 6)

Express Consent means the person or their substitute decision maker agrees, or not, to the collection, use or disclosure of personal health information. Express consent requires approval prior to collection, use or disclosure to begin. The consent can be indicated verbally or in writing

Implied Consent means a consent that is inferred through an individual's actions or alternatively, through their inactions. Implied consent can be revoked under *HIPA* by an individual.

Deemed Consent. Where an individual's personal health information is used and disclosed for the purposes for which the information was collected; for the purpose of arranging, assessing the need for, providing, continuing or supporting the provision of, a service requested or required by the individual, *HIPA* deems that consent exists. *HIPA* also provides that an individual has deemed consent for a trustee to share their personal health information to the individual's next of kin or someone with whom there exists a close personal relationship and the disclosure relates to the health services currently being provided to the individual, provided the subject individual has not expressed an objection to disclose. (s. 27)

There are some circumstances, outlined in *HIPA* where personal information may be released without consent. These are discussed later.

5. Collecting personal health information

"Collection" is defined by *HIPA* as to "gather, obtain access to, acquire, receive or obtain personal health information from any source by any means." (s. 2(b)) Personal health information must be collected directly from the individual "except where the individual is unable to provide the information" (s. 25(1)(b)), or consents to the collection by other methods, or collecting it directly would prejudice the health or the safety of the individual or others. When the information is collected from others, reasonable steps must be taken to verify the information. For example, if a person with a mental illness did not know or understand information about their symptoms or was not capable of providing the information because of the illness, the person would be "unable" to provide the information and indirect collection from a relative or other person would be justified.

6. Use of personal health information (s. 2(u))

"Use" indicates the internal utilization of personal health information by a trustee and includes sharing of the personal health information in such a way that it remains under the control of that trustee. For example, in a regional health authority and its facilities, the sharing of information between employees, volunteers and contractors, including physicians with privileges, constitutes "use" of the personal health information since the sharing happens under the control of the regional health authority. It is also defined by section 2(u) of *HIPA*.

7. Disclosure of personal health information

"Disclosure" is exposure of personal health information to a separate entity, not a division or branch of the trustee in custody or control of that information. For example, when a health region shares information with a family member, an insurer, media, Ministry of Health, the Saskatchewan Cancer Agency, Saskatchewan Workers' Compensation Board, lawyers, or police, this amounts to a disclosure. Occasionally this will be mandatory (*The Gunshot and Stab Wound Mandatory Reporting Act* and *The Public Health Act, 1994*) but the disclosure can only occur in accordance with *HIPA*, ie. express or deemed consent, or an exception allowing disclosure without consent as per s. 27(4) or sections 28 or 29.

Deemed Consent for Disclosure (s. 27(2))

A person does not have to give express consent - or indeed may object to - some information disclosures, but if the "deemed consent" provisions of *HIPA* apply, express consent is not required and an objection can be overruled. Circumstances where deemed consent operates are listed in s. 27(2).

s. 27(2) "A subject individual is **deemed to consent** to the disclosure of personal health information:

(a) for the purpose for which the information was collected by the trustee or for a purpose that is consistent with that purpose;

(b) for the purpose of arranging, assessing the need for, providing, continuing, or supporting the provision of, a service requested or required by the subject individual; or

(c) to the subject individual's next of kin or someone with whom the subject individual has a close personal relationship if:

(i) the disclosure relates to health services currently being provided to the subject individual; and (ii) the subject individual has not expressed a contrary intention to a disclosure of that type."

Clauses (a) and (b) provide deemed consent (express consent from the patient not required) for disclosure to others involved with the patient's care such as physicians, nurses, rehabilitation staff, other professional staff and care aides at the mental health centre. Clause (a) and certainly (b) could apply outside the mental health centre as well. For example, while a social worker would ordinarily obtain consent in arranging for financial assistance essential for discharge or finding a residence, this deemed consent provision could be used if consent was not forthcoming. Information disclosed would only be that necessary for that purpose. Clause (b) would also cover situations where, consistent with the purpose for which the information was collected, information could be disclosed to other health care providers, other regional health authorities, rehabilitation services, or residential or home care services because the services are required by the person. The information disclosed must be the minimum needed for that circumstance.

Clause (c) allows for disclosure to next of kin unless the person has objected. It appears to prohibit a family who, on discharge, are caring for a person with psychosis from receiving essential information about medication side effects, signs of relapse or handling aggression if the person has said that he/she does not want his/her family to be informed. However, (s. 27(4)(a)) reads "where a trustee believes, on reasonable grounds, that the disclosure will avoid or minimize a danger to the health or safety of a person" consent is not required. Certainly without that information there may be a danger to the health of the person and possibly the safety of the family. That decision process should be documented.

Where consent (express, implied or deemed) is not required

There are some exceptions to keeping personal health information confidential. These exceptions are prescribed in *HIPA*. Personal health information disclosed without the client's consent (other than in cases where deemed consent exists) could include:

- Routine consultations and discussion together with staff and other mental health/addictions services professionals within the program/clinic who are also bound by confidentiality for the purpose of case planning and provision of service of a mutual client.
- When a court of law subpoenas the clinical record and/or the testimony of the clinician.
- When there is an emergency and the clinician believes the client is likely to harm himself/herself or others. This situation needs to be well documented in the client's file.
- When the clinician has "reasonable belief" that a child is at risk or is being abused. There is an obligation on the clinician to report such beliefs under *The Child and Family Services Act*; to not report is punishable by law.
- If public interest demands a breach of confidentiality as under common law (i.e. serious crime, threats to others).

Disclosure without express, implied or deemed consent for health or safety reasons

Before a health care provider is authorized to disclose a client's personal health information without the client's express or deemed consent, the health care provider must review their program's process for disclosure of personal health information, as well as the legislation applicable to their program. The following relates to decisions to disclose to minimize a danger to the health or safety of any person.

As per clause 27(4)(a) of *HIPA*, a trustee may disclose personal health information "where the trustee believes, on reasonable grounds, that the disclosure will avoid or minimize a danger to the health or safety of any person."

All of the following criteria must be present:

a) Is there a reasonable expectation of probable harm?

Reasonable expectation of harm refers to a confident belief that harm will occur to an identifiable person(s). The likelihood of the occurrence of harm must be genuine and conceivable. In other words, the probability of the harm must be more than a cautious approach to the avoidance of any risk.

b) Would the harm constitute damage or detriment and not mere inconvenience?

Is the degree of anticipated harm significant? The harm must relate to serious physical injury or mental trauma or danger to an identifiable individual(s).

c) Is there a causal connection between the disclosure and the anticipated harm?

There must be a clear and direct link between the disclosure of specific information and prevention or minimization of the alleged harm. The trustee must be able to provide an explanation as to how or why the disclosure will prevent or minimize the expected harm.

To a Substitute Decision Maker

Substitute decision makers of incapable patients who make health care decisions on behalf of voluntary patients or decisions about non-mental health care for involuntary patients can receive information necessary to make their decision without consent. (s. 27(4)(d))

To Provide Beneficial Health or Social Services if not Reasonably Practical to Obtain Consent

> s. 27(4)(j) "…subject to subsection (6), where the disclosure is being made for the provision of health or social services to the subject individual, if, in the opinion of the trustee, disclosure of the personal health information will clearly benefit the health or well-being of the subject individual, but only where it is not reasonably practicable to obtain consent;
>
> s. 27(6) Disclosure of personal health information pursuant to clause (4)(j) may be made only where the person to whom the information is to be disclosed agrees:
>
> (a) to use the information only for the purpose for which it is being disclosed; and
>
> (b) not to make a further disclosure of the information in the course of carrying out any of the activities mentioned in that clause."

Section 27 provides that where it is not "reasonably practical" to obtain consent, information can be disclosed for the "provision of health or social services if disclosure will clearly benefit the person." If a person with a mental illness is not capable of understanding and appreciating the need to provide this type of information for his or her health or social service needs, then it would not be reasonably practical to obtain consent and the trustee could rely on the disclosure without consent exemption provisions in *HIPA*.

Best practise requires documentation of the decision in the patient's file.

Other Situations where Consent is not required (unlikely to be relevant)

Section 27 contains a list of circumstances where information can be released without consent. The list includes circumstances surrounding: misuse of publicly funded health services, transfer from one trustee to another, deceased persons, information management, quality of care committee, professions for regulation purposes, court or tribunal proceedings, obtaining payment, service planning and delivery, required by another law, to trustee's legal counsel and drug program monitoring. Section 28 lists registration information and other administrative circumstances.

8. Case Scenarios

Adult Scenario

The purpose of this section is to illustrate how the personal information collection, use and disclosure authority of *HIPA* plays out in a fictional mental health case. It should be noted that people who are under *MHSA* have challenges with symptoms such as delusions, thought disorder, hallucinations, mania and others that can interfere with their judgement as to what is in their best interests including making decisions to collect or disclose personal health information. Indeed to be an involuntary patient under *MHSA* a person must be incapable of making a treatment decision although they may be capable of making a decision to collect or disclose information.

Bob is a 21 year old who lives in his single mother's basement suite. He has recently been fired from his part time job. The manager told Bob's mother that customers felt intimidated by Bob's odd behaviour and possible death threats. Bob expresses delusions about aliens including that she is not his mother but an alien. He appears to be hallucinating and rarely comes out of his room. He finally agrees to see a physician after his mother threatened him with eviction. The physician sees Bob and talks to the mother. Bob believes there is nothing wrong with him, and is convinced that aliens do talk to him. The physician completes a Form A under the MHSA and calls the police to escort him to hospital because he is very angry about being hospitalized.

His response to treatment in hospital is complex, with many medication side effects and changes. After one month his delusions have abated somewhat and he is discharged to his mother's care and home. Approximately 10 hospital staff are engaged in Bob's care and a case conference is held about his situation including staff not directly involved in his case. Bob does not want this to happen. As part of his discharge plan, social services and other programs need to be set up but Bob says he does not want hospital staff talking to anyone about him.

Throughout his hospitalization his mother has been very concerned about him, wanting to be involved in care planning conferences and is very much involved in his aftercare. Bob does not want the staff talking to his mother although he does want to continue to live in her home. He is advised that he should stay on his medication and have regular visits with his physician.

On discharge, Bob lives in his mother's house for a month. He then leaves for an unsupported apartment living by himself. He is less symptomatic, but has not regained insight into his mental health issues. He must take medication to stay well but without his mother's help he neglects to take medication and neglects reasonable nutrition, hygiene and recovery services.

What *HIPA* issues are raised in this case?

Collection issues: A "trustee [the physician] shall collect personal health information directly from the subject individual , except where… (b) the individual is unable to provide the information" ...or "(c) that collection directly from the subject individual would

prejudice the mental or physical health or the safety of the subject individual or another individual." (s. 25(1))

Physician: The physician clearly has the authority under s. 25(1)(b) to collect information indirectly from the mother because Bob will not be able to describe all the signs and symptoms necessary for the physician's decision. If the physician were concerned that discussing Bob's delusions about his mother might prejudice his health or his mother's health or safety, that would also be a justification for indirect collection under s. 25(1)(c).

In examining Bob under the *MHSA*, Form G criteria, the physician with admitting privileges considered it necessary to confirm the mother's information that the employer had reported possible death threats against customers. Section 25(3) states "the trustee must take reasonable steps to verify the accuracy of the information" and that would justify that enquiry. However, contacting the employer could stigmatize Bob since it would disclose at least that Bob was being examined by a physician in the mental health system. Do any of the exceptions to consent in s. 27(2) to (4) apply? It might be argued that s. 27(1)(a) does because the disclosure that Bob is being seen by the physician is to obtain information for the purpose for which it is collected; that is to decide if the "harm" criterion is met for the involuntary examination criteria in Form G. The physician may need the information from the employer to determine if Bob, who denies all symptoms except hallucinations of contact with aliens, is likely dangerous to others and whether he meets the *MHSA* involuntary criteria. Obviously this is a judgement call.

Peace Officer: The peace officer who accompanied Bob to the hospital has an obligation to keep information confidential he or she has collected through conversation and observation with or about Bob. However, when the examining physician or other hospital staff want to collect written or verbal information from the officer, that could be justified under s. 25(1)(b) since Bob would not be able to provide that information.

Staff directly involved in Bob's care: Ideally, the admitting psychiatrist would obtain permission from Bob or from his substitute decision maker to share information with other staff who are helping him. If that is not forthcoming, deemed consent can be relied upon because the disclosure to other staff is:

> "(a) for the purpose for which the information was collected by the trustee or for a purpose that is consistent with that purpose; [or]
>
> "(b) for the purpose of arranging, assessing the need for, providing, continuing, or supporting the provision of, a service requested or required by the subject individual." (s.27(2) (a) and (b))

Staff not directly involved in Bob's care: A case conference, including people from the centre who will never see Bob, was held to plan for Bob's recovery and release. Since this case conference is for the same purpose the information was collected for (getting Bob better) s. 27(1)(a) and also for supporting the services requested or relied upon like

discussing housing and medication options, (s. 27(1)(b)), Bob's express permission for the people to disclose his personal information at the meeting would not be required. If there were people from outside agencies attending the meeting for the purposes of providing assistance related to Bob's mental health treatment and care then deemed consent would apply and Bob's permission would not be required. However, people there as students or other observers not related assisting in Bob's care would require Bob's permission, or that of his substitute decision maker.

Another option might be to redact the information by not using Bob's name in the conference. However, that may not be practical if Bob comes to part of the case conference or there are documents identifying him.

Family caregiver in the inpatient setting: Bob's mother wants to meet with Bob's attending physician and two nurses on the unit to discuss discharge planning that will involve the staff disclosing personal health information. Bob has made it very clear he does not want his mother "interfering" with his life, yet he wishes to live in her home and she will be involved in his care. What authority do the staff have to discuss these issues with the mother?

The authority to provide information to next of kin in s. 27(2) does not apply because Bob has "expressed a contrary intention to a disclosure of this type." However, since the disclosure is "for the purpose of arranging, assessing the need for, providing, continuing, or supporting the provision of, a service requested or required by the subject individual" such as the mother ensuring that he takes his prescribed medication s. 27(2)(b) would apply and the staff could disclose necessary information without Bob's consent.

Since he will be living in his mother's house and she will be supervising medication and monitoring treatment effects it could be argued that the information can be provided on a need to know basis because she needs to understand the potential side effects and main effects of the medication, how to handle Bob's anger or withdrawal, and if there are safety concerns around children. The staff could rely on **deemed consent** of s. 27(2) "where a subject individual is deemed to consent to the disclosure of personal health information (a) for the purpose for which the information was collected by the trustee or for a purpose that is consistent with that purpose." The information is for the purpose of keeping Bob well by educating a person who will have an important role to play in maintaining Bob's mental health.

Family in mother's house: Bob is discharged to his mother's home despite his feelings about her, and she "supervises" him in the sense of seeing that he takes his medication, listening for any signs of emerging psychosis, etc. Bob still does not want his mother to speak with the staff. However, she asks the community staff about medication levels, the best way to handle his insomnia and reclusiveness, and other concerns. The staff must reveal information they have about Bob to respond to the requests which they believe are entirely for the purpose for which the information was collected; namely treating Bob's psychosis

and keeping Bob well. Staff can provide that information despite Bob's objection. The deemed consent provision of *HIPA* would justify this as follows:

> "s. 27(2) A subject individual is deemed to consent to the disclosure of personal health information:
>
> (a) for the purpose for which the information was collected by the trustee or for a purpose that is consistent with that purpose."

Children and information sharing

Generally, where the parent is the guardian of the child, the parent can give permission to collect or release information using the *HIPA* rules as the parent or guardian provides consent. For youth involved with the criminal justice system, *HIPA* does not apply to records protected under the *Youth Criminal Justice Act*. Staff should consult with a knowledgeable person on these issues. Individuals under the age of 18 years of age who understand the nature of the rights or powers and the consequences of making a decision relating to information about the individual (also known as "mature minors") can make their own health information decisions and *HIPA* applies to them and their circumstances. (s. 56(c))

Child Scenario

The school calls Child and Youth Mental Health Services requesting information urgently on John, a 15 year old male student in Grade 9 whom they had referred in Grade 8 because of his very oppositional, defiant and uncooperative attitude since he entered grade 1. However, this year, his behavioural problems are escalating. For example, he is much more forcefully threatening to retaliate against his science teacher. John is also negatively influencing other students in the classroom to act out with him. The school wants to know what treatment John is getting through Child and Youth Services, and in particular if he is getting 'strong-enough' medication. They also want some direction on how to handle his problematic behaviour.

John, an only child of a single (custodial) mother, is still an active client at Child and Youth.

To Child and Youth there are two apparent needs:

- "to avoid or minimize a danger to the health or safety of any person" (s. 27)(4)(a) and
- "to provide, continue, or support the provision of a service required by the subject individual." (s. 27(2)(b))

However, in this case, the key question for Child and Youth is whether disclosing the information without consent is "required"; that is, would the youth make no progress or deteriorate significantly if the information were not provided?

The first option is for the school to get the informed consent of the parent or the youth if the youth is a mature minor to obtain this information from Child and Youth. (s. 6) If the

youth is not a mature minor, but a child under 18, the parent can give permission to Child and Youth to disclose the information to the school where Child and Youth, as the trustee, is of the opinion that disclosure would not constitute an unreasonable invasion of the privacy of the child (s. 56(d)). If the youth (as a mature minor) refuses to permit disclosure to the school, the mature minor has the authority to make this refusal (s. 56(c)), and his mother will not necessarily have the ultimate say even though the youth is a minor in the parent's custody. Another possible justification for disclosure is s. 27(2). Child and Youth will only disclose the information needed by the school to meet those two needs and seek reassurance from the school that it will only be used for those purposes by only those who need to know and be kept confidential. (s. 6)

If the parent or the mature minor refuse to consent, *HIPA* provides authority for Child and Youth to disclose the information without consent to meet the first need (s. 27 (4) (a)) "to avoid or minimize a danger to the health or safety of any person") but not the second need (s. 27 (2) (a) and (b) "to provide, continue, or support the provision of a service required by the subject individual") because the extension of the treatment into the school is thought to be beneficial, but not essential at this point in time. If there is, subsequently, consent to the disclosure of information, or receiving the information becomes "required", Child and Youth will disclose the information to the school for that expressed purpose (s. 6) and continue to point out the advantages of full disclosure.

9. Other *HIPA* issues

Access to one's own file

Bob demands to see his file while in hospital because he says it will be full of lies told by his mother to the staff. Does he have a right to see his file and correct notes he thinks are wrong? Section 32, 33 and 34 show that Bob can make an oral or written request for personal health information contained in a "record." And if the request is in writing, the trustee shall provide explanation of terms, abbreviations and codes in the record. Within 30 days after receiving a written request, the trustee must respond in one of three ways:

(i) Providing a copy of what the applicant requested,

(ii) Informing the person that the information does not exist or cannot be found, or

(iii) Refusing the request in whole or in part and informing the person.

The trustee can refuse to provide copies of the file or parts of the file in accord with s. 38(1): Subject to subsection (2), a trustee may refuse to grant an applicant access to his or her personal health information if:

"in the opinion of the trustee, knowledge of the information could reasonably be expected to endanger the mental or physical health or the safety of the applicant or another person."

Amending your own file

While Bob cannot amend the information provided by his mother since it has been denied to him, he can request an amendment. Factual errors, omissions or inaccuracies may be amended. If the amendment is not made, he can require that a notation to that effect be made in the record.

Appeals

Appeals may be made to the Privacy Commissioner about the following issues:

- Refusing the written request for access, in whole or in part, to one's record.
- Not making a requested amendment to the record.
- The *Act* has been contravened in some way.

10. Getting help on *HIPA* issues

All regional health authorities have privacy officers who address *HIPA* issues.

11. Other requests for information (e.g. police, insurance companies)

Disclosures and request for disclosures of personal health information (with or without client consent) must be documented in the client's chart, specifically:

a) The name of the person(s) / organization(s) to whom the care provider disclosed the personal health information;
b) The date and time of the disclosure;
c) The purpose of the disclosure;
d) A description of the personal health information disclose; and
e) Documentation of patient/client/resident consent (if applicable).

Where the disclosure is made without consent, the trustee must take reasonable steps to ensure that the client is informed that their personal health information was disclosed. This does not apply if there is deemed consent. (s. 27(2))

The police could be provided with information when they request it. For example, if they have been called to assist with a person, believed to be a former patient, who has barricaded themselves into a home and is indicating that they may commit suicide, the police would want to know the names and contact details of relatives in mental health centre files who may be able to talk them out of suicide. Or the police may want information that will help them find a missing person in danger of harm who was a previous patient.

Ordinarily these requests would be referred to the privacy officer for the trustee or senior management but s. 27(4)(a) might justify release to "avoid or minimize a danger to the health or safety of any person." Requests for information that might assist in a criminal investigation where there is danger to the safety of any person would be authorized under s. 5.1 of The Health Information Protection Regulations.

Requests from insurance companies or others seeking personal health information without a court or other order would not ordinarily be honoured unless there was consent or one of the exclusions applied to the specific circumstance.

12. *HIPA* function in the private health service field

Most of the personal health information issues likely to be encountered when dealing with *MHSA* are addressed by *HIPA*. However, it is possible that a situation may arise where a trustee as defined by *HIPA* is not involved, such as in the private medical care field. In instances where *HIPA* does not apply, *The Personal Information Protection and Electronic Documents Act* (PIPEDA) applies. Most information offices in regional health authorities will be able to provide guidance.

Appendix 11

Nurse Responsibilities

This appendix will discuss the following:

1. Definition
2. Specific responsibilities of a nurse under the *MHSA*
3. Possible roles of a nurse under the *MHSA*

1. Definition

The *Mental Health Services Act (MHSA)* defines a nurse as a registered nurse as defined by *The Registered Nurses Act, 1998*, or a registered psychiatric nurse as defined in the *Registered Psychiatric Nurses Act*. (s. 2(q))

2. Specific responsibilities of a nurse under the *MHSA*

Temporary hold for voluntary patients

Where a nurse in a mental health centre (inpatient unit designated to be able to detain involuntary patients) believes that a voluntary patient intends to leave the mental health centre, and the nurse believes on reasonable grounds that the patient should be held because they meet the involuntary admission criteria, the nurse can detain the person for up to three hours while the person is examined. Section 30.1 provides the authority:

> s. 30.1(1) "A nurse in a mental health centre may detain or cause to be detained and, if necessary, restrain or cause to be restrained a voluntary patient requesting to be discharged if the nurse believes on reasonable grounds that the patient:
>
> (a) has a mental disorder;
>
> (b) because of the mental disorder, is likely to cause serious harm to himself or herself or to another person or to suffer serious mental or physical deterioration if the patient leaves the mental health centre; and
>
> (c) needs to be examined by a physician or a resident in psychiatry.
>
> (2) A patient who is detained pursuant to subsection (1) must be examined by a physician or a resident in psychiatry within three hours after the detention commenced."

The three hour hold does not give the nurse the authority to prescribe medications or treat the patient with medications without a doctor's order.

If the examining physician does not have admitting privileges to the mental health inpatient centre, they will need to complete a Form A to have authority to hold the patient beyond the three hours.

The nurse should:

- Inform the patient that the *MHSA* requires the patient to stay until the physician arrives to see them.
- Call for back up assistance if necessary, including security or the police, if restraining the patient may result in injuries or the person leaving if security or the police are not in attendance.
- Contact the patient's psychiatrist if available, and if not available, contact the on-call psychiatrist or a resident to remind them of the urgency of the matter.
- Release the patient if a physician or resident cannot be found after three hours if the patient does not want to stay. If there is imminent danger (e.g. suicide or assault) the patient can be restrained on common law grounds.
- Document the incident in the patient's chart.
- **Note:** it is only a nurse in a mental health centre and a voluntary patient in a mental health centre who can be involved in the three hour hold. A voluntary patient who is in the emergency department would not qualify for this hold because the emergency department is not designated as a mental health centre. Similarly a nurse who was not assigned to the mental health centre could not activate the hold for a patient in the mental health centre.

3. Possible roles of a nurse under the *MHSA*

These functions may be designated to other health professionals as well as nurses.

(i) Prescribed health professional (Form A certificates and Community Treatment Order Compliance)

Registered psychiatric nurses and registered nurses may be prescribed health professionals if they satisfy the minister that they are employed by a regional health authority; have at least five years' of experience in the past 10 years working in the mental health field; and practise in a rural or remote area of Saskatchewan where access to physician services is limited. (Regulation 11.1(1))

A prescribed health professional may complete a Form A. (s. 18) In addition, prescribed health professionals may order a person on a community treatment order who is not complying with the order to be apprehended and conveyed for a psychiatric examination. (s. 24.6)

The prescribed health professional may only act if an attending physician is not available and the prescribed health professional has reason to believe that an physician will not be available within a reasonable period. (Regulation 11.1)

(ii) Other duties related to the *MHSA*

In addition to the many clinical functions nurses have in the admission, treatment, support, care, discharge and community treatment of patients admitted under the *MHSA*, there are a number of other functions nurses have including explaining patient and family rights, keeping track of certificate expiry dates, reporting to review panels, supervising community treatment orders and providing information to other clinicians and family members. However, none of these functions are specifically referenced for nurses in the *MHSA*.

Appendix 12

Psychiatrist, Physician and Resident Responsibilities

Under *The Mental Health Services Act (MHSA)* and Regulations, psychiatrists, physicians and residents in psychiatry have the following responsibilities:

Chief Psychiatrists:

- Clinical services in the regional health authority.
- Functions normally performed by a department head.

Psychiatrists:

- Authorize diagnostic, assessment and treatment services according to s. 25 in collaboration and within the means of the mental health centre.
- Issue one of the two certificates of medical practitioners for compulsory admission of a person to a mental health centre. (Form G, s. 24)
- Issue a Community Treatment Order. (Form H.3, s. 24.3)
- Issue a certificate in support of a Community Treatment Order. (Form H.4, s. 24.4)
- Certify when ECT is required for involuntary patient. (Form I, Regulation 14(4)(d))
- Transmit copies of ECT certificates (Form I) to an official representative for the region. (Regulation 14(f))

Attending Psychiatrists/Physicians:

- Provide assessment and treatment services to inpatients (s. 25, 27) and outpatients. (s. 24.7)
- Revoke committal certificates. (Form H, s. 24(9), 31(1)(a))
- Provide notice of expiry or rescinding of a Court of Queen's Beach long term disability order. (Form H.2, s. 24.1(8))
- Notify patient when Community Treatment Order is no longer in effect. (Form H.5, s. 24.5(2))
- Revoke Community Treatment Order (Form H.6, s. 24.5(3)(a)) and inform patient. (s. 24.5(3)(b))
- Issue order for involuntary examination in case of non compliance with Community Treatment Order. (Form H.7, s. 24.6)

- Order the transfer of an involuntary patient to another inpatient facility in the same municipality. (Form L.1, s. 28 (5) & (6))
- Authorize temporary absence and return of involuntary inpatient to be made in writing. (s. 29 and Regulation 43(12))
- Order that an involuntary patient who has left an inpatient facility without being discharged be returned to the facility. (s. 30(1))
- Inform patient of revocation of Form G certificates. (Form L.3, s. 31(1) (a))
- Authorize the discharge of inpatient. (s. 31)
- Notify an official representative for the region of revocation of Form G certificates by transmitting a copy of the revocation order (Form H, s. 31(1)(c)) to the official representative.
- Give notification regarding right of appeal against involuntary ECT. (Form J, Regulation 14(4)(g))
- Give notification regarding appeal procedures to the inpatient, the nearest relative and an official representative for the region. (Form M, s. 33)
- Send notice for mandatory review of continuing detention (beyond 21 days and at 6-monthly intervals) to the chairperson of the review panel. (Form N, s. 34(5))
- Receive notice of appeal hearing. (Regulation 21(1)(a))
- Provide a statement to the review panel. (Form O, Regulation 22)

Psychiatrist/Physicians with Admitting Privileges to a mental health centre:

- Provide voluntary examination and treatment services for persons who request and consent. (s. 17)
- For persons who are compelled to be examined:
  - i) examine persons as required pursuant to certificates, orders or warrants (s. 18, 19, 20, 21, 22, 23.1);
  - ii) issue Certificate of Medical Practitioners for Compulsory Admission of a Person to an Inpatient Facility (Form G, s. 24); and
  - iii) issue Certificate of Medical Practitioners for Compulsory Community Treatment Order. (s. 24.3)

Residents in psychiatry under the supervision of a psychiatrist with admitting privileges to a mental health centre:

- Issue a Form G as long as the other Form G is not issued by another resident, or the resident's supervisor. One of the Form Gs must be by a psychiatrist.
- As a prescribed health professional, issue an order (Form H.7) for a person to be taken for a psychiatric examination where the person on a CTO fails to comply only if an attending physician is not available and the prescribed health professional has reason to believe that an attending physician will not become available within a reasonable period.
- As a prescribed health professional, conduct examination and issue a Certificate of Physician that Psychiatric Examination is Required (Form A, s. 18), only if an attending physician is not available and the prescribed health professional has reason to believe that an attending physician will not become available within a reasonable period.

Any Physician:

- Conduct examination and issue Certificate of Physician that Psychiatric Examination is Required. (Form A, s.18)
- Transmit copy of above certificate to an official representative for the region. (Regulation 11)
- Examine a person who has been apprehended by police. (s. 20)

Appendix 13

Forms Under *The Mental Health Services Act* or *The Mental Health Services Regulations*

Prescribed Forms (are included at the back of The Mental Health Services Regulations)

Form	Name	Section of Act or Regs	Who Signs	When	Expiration Date
A	Certificate of Physician or Prescribed Health Professional that Psychiatric Examination is Required	S.18	Any physician or prescribed health professional in absence of Physician	Within 7 days of examination	Seven days after examination
B	Information	S.19 (1)	Provincial Court Judge	Within 7 days	Seven days after date of issue
C	Warrant to Apprehend	S.19 (2)	Provincial Court Judge	Within 24 hours	Seven days after date of issue
D	Order for Person from Outside Saskatchewan to be Taken into Custody, Conveyed and Examined as an Out-patient	S.21	Provincial Director	Within 24 hours of being brought into Saskatchewan	Seven days after date of issue
E	Order to Convey Person in Custody for Voluntary Examination	S.22 (2)	Provincial Court Judge	Upon request of person in custody	No statutory restriction
F	Order for Psychiatric Examination as Out-patient	S.22 (3)	Provincial Court Judge	Once person has been charged with an offence	No statutory restriction
F.1	Order by the Director Requiring that a Person Submit to an Examination	S.23.1	Provincial Director	When detention under Criminal Code is about to expire	No statutory restriction

Form	Name	Section of Act or Regs	Who Signs	When	Expiration Date
G	Certificate of Medical Practitioners for Compulsory Admission of a Person to a Mental Health Centre	S.24	Physician with admitting privileges / Resident in Psychiatry under the supervision of a Psychiatrist with admitting privileges	Within 7 days after examination prior to committal	End of 3rd day, with 1 certificate OR end of 21st day with 2 certificates
H	Revocation of Certificate of Committal	S.24 (10) & 31 (1) (a)	Attending physician	When committal criteria no longer apply	N/A
H.1	Order by a Judge for Detention of a Person	S.24.1 (3)	Local registrar or Court of Queen's Bench	When criteria for LTD have been met	Maximum of 1 year
H.2	Notification that a Detention Order has Expired or Been Rescinded	S.24.1 (8)	Attending physician	When order expires or is rescinded	N/A
H.3	Community Treatment Order	S.24.3	Examining psychiatrist	When CTO criteria apply	Time period specified in order (max. 6 months)
H.4	Certificate in Support of a Community Treatment Order	S.24.4	Second examining psychiatrist	When 2nd psychiatrist concurs with CTO	Time period specified in order
H.5	Notification by an Attending Physician Advising a Patient that a Community Treatment Order is no Longer in Effect	S.24.5 (2)	Attending physician	When CTO expires	N/A
H.6	Order to Revoke a Community Treatment Order	S.24.5 (3)	Attending physician	When CTO is revoked	N/A

Form	Name	Section of Act or Regs	Who Signs	When	Expiration Date
H.7	Order for the Apprehension, Conveyance and Examination of a Person (in Respect to a CTO)	S.24.6	Attending physician or prescribed health professional in absence of physician	When person fails to comply with CTO requirements	No statutory restriction
I	Certificate for Electroconvulsive Therapy (involuntary status in place)	S.14 of regs	Two psychiatrists	When ECT considered essential	After 12 sessions or expiry of authority to detain, whichever occurs first
J	Notification Regarding Appeal Procedures	S.14 (4) (g) of regs	Attending physician	Upon issuance of Form I	N/A
K	Order for Transfer	S.28	Provincial Director	No statutory restriction	No statutory restriction
L.1	Order of a Physician to Transfer a Patient from One Facility to Another Facility within the Same Municipality	S.28 (5)	Attending physician	At any time while a patient is detained under s 24	N/A
L.2	Order by the Director to Return a Person to Another Jurisdiction	S.28.2 (3)	Provincial Director	Any time during stay of involuntary patient	No statutory restriction
L.3	Notice by an Attending Physician Advising a Patient that He or She is no Longer Subject to Detention Pursuant to Section 24	S.31.1	Attending physician	When Form G certificate(s) expires and is not renewed	N/A
M	Notification Regarding Appeal Procedures	S.33	Attending physician	Immediately upon s.24 committal, CTO or s.28 transfer	N/A

Form	Name	Section of Act or Regs	Who Signs	When	Expiration Date
N	Appeal to Review Panels	S.34 & S.24 (2) of regs	Patient or representative	Certification for all detention, treatment, transfer situations except s.24.1	N/A
O	Statement by Attending Physician to Review Panel	S.22 of regs	Attending physician	Within 24 hours of notice of appeal	N/A
P	Authorization for Money to be Held in the Patients' Trust Account	S.34 (1) (b) of regs	Patient	Any time	When rescinded by patient or upon discharge

Non-prescribed Forms

- Authorization for an Involuntary Patient to Receive Medical Services on a Hospital Unit Other Than a Designated Unit (s.29)
- Consent for General Diagnostic and Treatment Services and Procedures on Voluntary Admission under The Mental Health Services Act (s.17)
- Decision of Review Panel (s.24(1)(6) R)
- Release of Information (s.17 R)
- Temporary Hold for Voluntary Patients by a Nurse in a Mental Health Centre (s. 30.1 (1))

- All forms prescribed and non-prescribed approved by the Ministry of Health are located on the Queen's Printer website:

  http://www.qp.gov.sk.ca/index.cfm?fuseaction=publications.typelist&c=212

Appendix 14

Frequently Asked Questions

Form A

1. Can an Ambulance transport a client under Form A or does a peace officer need to be involved?

   Answer: Any person can execute an apprehension pursuant to a Form A or Judge's warrant if that person is named to do so in the Form A or Judge's warrant. Typically a Judge's warrant is carried out by a peace officer. However, only the police have authority to use reasonable force when conveying the individual. (See **Appendix 5: Completing Form A** #11)

2. If EMS staff in rural area transfer a client to mental health centre, do they need to stay with the patient until the psychiatrist has assessed the individual?

   Answer: Only the person named to carry out an apprehension pursuant to a Form A has authority to detain that person. There is no authority under the *MHSA* that allows for detention of the person to be transferred to another person. If the EMS staff does not stay with the patient until the psychiatrist assesses the individual, there is risk that the patient could simply leave the mental health centre.

3. Can a peace officer refuse to convey a person under a Form A to the nearest designated Mental Health Centre?

   Answer: The *Act* does not compel and peace officer to convey but depending on the circumstances it would be hoped the police would provide assistance. The alternative for a peace officer is that the Form A list some other person to carry out the apprehension and conveyance of the individual to the place where examination can occur. (See **Appendix 5: Completing Form A** #4)

4. The *Act* states Form A should state the name of the physician with admitting privileges to the Mental Health Centre. Does this mean that all Emergency Department Physicians will require admitting privileges?

   Answer: No. Section 18 requires that the Physician carrying out the Form A examination is to make arrangements with a Physician with admitting privileges to a Mental Health Centre. This would be referring to the actual Physician who will carry out the psychiatric examination and determining if the patient should be admitted and detained per Section 24.

Form G (Guide Chapter 5.4 Admission on medical certificates (Form G) (s.24))

5. Until the new *Act* is proclaimed should form G's be allowed to lapse or do they need to be revoked?

   Answer: They need to be revoked.

6. If a non-psychiatrist with admitting privileges completes the first form G who can complete the second?

   Answer: A least one Form G must be completed by a psychiatrist.

7. If one Form G has been issued, the second Form G must be completed before the end of the third day following the day of admission If the person no longer fits the criteria prior to the 2nd Form G being completed, is it appropriate to allow the first form G to lapse or should it be revoked?

   Answer: The *Act* states under 31(1)(a) that a current certificate be revoked and not simply be allowed to lapse.

8. If an involuntary patient is transferred to another Regional Health Authority MHC does the Form G process need to be repeated?

   Answer: The *Act* does not specifically require an accepting RHA to complete a new set of certificates and therefore the person could be admitted without renewing the process.

9. Can an appeal be made with only the first Form G in place?

   Answer: S. 34(2) of the *Act* provides that a person described in 33(1)(a), namely a person subject to detention in a MHC pursuant to section 24 (which could include either detention on one or two certificates), can submit an appeal in writing to the chairperson of the review panel. This is subject to the condition in 34(4) that if the person has previously exercised his right to appeal, that two new certificates under s. 24 have been issued since that previous appeal.

Form G time periods: (Guide Chapter 5.4 Admission on medical certificates (Form G) (s.24))

New patient with Form G completed in Emergency Department:

10. When does the three day detention period time limit begin?

    Answer: s. 24(5) provides the following: "If this is a new patient, the patient can be admitted to a MHC on issuance of one certificate. The three day detention period begins at the time that the patient is admitted <u>to the MHC</u> pursuant to that first Form G."

11. After admission, when do Form G's expire for patients with a Form G completed in Emergency Department?

    Answer: When two valid Form G certificates are in place, they expire at the end of the 21st day (midnight) following the date the patient was admitted to the MHC on completion of the first Form G.

Existing MHC voluntary patient requiring certification:

12. If the first form G is signed for an existing MHC patient, when does the three day time period time limit start?

    If this is an existing MHC patient, the three day detention period begins at the time that the first Form G is issued.

13. When do Form G's expire for an existing MHC voluntary patient who becomes certified?

    Answer: When two valid Form G certificates are in place they expire at the end of the 21st day (midnight) following the date upon which the first form G was issued if the person was an inpatient when the first form G was issued.

Form K

14. In the new *Act*, who will sign Form K's?

    Answer: The Provincial Director of Mental Health Serves will continue to sign Form Ks. (See Chapter 5.12 Transfer (s.28))

Peace Officer

15. Can a peace officer use force to enter a dwelling house to execute a *MHSA* warrant or without a warrant under sections 18, 24 or 24.6?

    Answer: The *MHSA* provides authority for a peace officer or other designated person to use reasonable force to convey a person to a mental health centre, but does not provide authority for a peace officer to enter a dwelling house. A peace officer may enter a dwelling house to apprehend a person if permission to enter the dwelling is obtained or emergency situations exist. (see **Appendix 7: Peace Officer Responsibilities** #6)

16. Does a peace officer have to stay with an individual at the hospital until they are examined by a psychiatrist?

    Answer: A peace officer who conveys an individual to a mental health centre on a Form A request, a section 20 apprehension, or a judge's warrant retains custody of the individual until the person can be examined by a physician with

admitting privileges to a mental health centre. These sections of the Act do not provide authority for the individual's detention to be transferred to the hospital staff. As a result, if the peace officer does not remain with the individual until the psychiatric examination takes place; there is risk that the individual leave. (See **Appendix 7: Peace Officer Responsibilites** #2)

17. If a peace officer apprehends someone with or without a warrant does this mean they will be admitted?

    Answer: No. The individual needs to be examined by a physician with admitting privileges to determine if they need to be admitted. (Guide Chapter 5.4)

18. Can a peace officer apprehending a person under sections of the Mental Health Services Act in a rural area transfer the patient to another peace officer?

    Answer: This authority is not available in the MHSA, although might be available to officers pursuant to their authorities as peace officers.

Patients Requiring Acute Medical Care Outside Mental Health Centre

19. Can an involuntary patient be admitted to a general ward in hospital?

    Answer: An involuntary patient can only be admitted to a designated mental health centre. (Guide Chapter 3.1)

20. If a certified patient needs acute care, can they be transferred to an acute care ward? Is there a form?

    Answer: Section 29 "Temporary removal and return" allows an involuntary patient to be removed from a MHC to an "appropriate place if the patient requires care. (Guide Chapter 5.9)

    No form as part of new Regulation.

21. Can the *MHSA* be used to certify and treat a person with a medical condition who is not capable of making the treatment decision?

    Answer: The *MHSA* does not provide authority to treat persons incapable of making treatment decisions unless the person is an involuntary patient under the *MHSA*. *The Health Care and The Substitute Health Care Decision Makers Act* should be used for persons incapable of making treatment decisions where they are not also involuntary patients under the *MHSA*. Mentally challenged persons would be an example. (Guide Chapter 5.11)

Temporary Hold by Nurses in Mental Health Centre

22. Does the new section allowing for nurses to hold a voluntary patient for three hours apply to the emergency wards or other wards?

    Answer: No, the three hour hold only applies to a voluntary patient in a mental health centre. (See **Appendix 11: Nurse Responsibilities** #2)

23. Do the new temporary hold provisions allow a nurse to prescribe medications?

    Answer: No, the prescribing of medications and other forms of treatment against a persons will are not the discretion of a nurse during the temporary hold. (See **Appendix 11: Nurse Responsibilities** #2)

24. The temporary hold section refers to an exam by a physician, not a physician with admitting privileges, what are the implications?

    Answer: In most situations a physician with admitting privileges would be called. If the physician did not have admitting privileges they would have to complete a Form A for authority to continue to hold the person. (See **Appendix 5: Completing Form A** #1)

25. Would a nurse practitioner have authority to prescribe medication during a three hour hold?

    Answer: Section 33.1 does not provide authority for the nurse to prescribe medications to a person being held. Section 25 provides that except in an emergency, a voluntary patient is not to receive diagnostic or treatment services or procedures except if that person consents (or the person's proxy, nearest relative, etc. consents in the event that the person does not have capacity). (See **Appendix 11: Nurse Responsibilities** #2)

26. Could a nurse or nurse practitioner administer medication that had previously been prescribed by a physician (PRN)?

    Answer: Section 25 provides that except in the case of an emergency, where a patient is in a MHC per s. 17 (voluntary admission), no diagnostic or treatment services or procedures are to be carried out on the patient except with the consent of the patient or consent of proxy, nearest relative, etc. – so, the answer is yes if the patient consents, or if it's an emergency. (See **Appendix 11: Nurse Responsibilities** #2)

27. Is there a form for a Temporary Hold?

    Answer: Not in the Regulations. Since the form is not prescribed, either the form could be created through SK-wide or region-by-region policy basis.

Mental Health Centre Temporary Leave

28. Can a certified patient be allowed temporary leave from a mental health centre for other than health care services?

    Answer: Yes, this can occur pursuant to section 29, the activity must be a "benefit to the patient" and authorized by the attending physician. The attending physician can outline the purpose of the activity and who has supervisory responsibility and any restrictions. (Guide Chapter 5.9)

Community Treatment Order

29. How specific does the residence clause have to be when completing a CTO?

    Answer: The residence must be specified. (See **Appendix 8: Community Treatment Orders** #4)

30. If a worker or residence named in a CTO changes does a new CTO have to be issued?

    Answer: No, if a person named in the CTO moves or their worker changes, the attending physician or the person authorized to supervise the CTO can make a note to file without going through the process of issuing a new CTO. (See **Appendix 8: Community Treatment Orders** #4)

31. How often can a person on a CTO appeal?

    Answer: Voluntary appeals may be made by the patient OR, nearest relative, proxy or personal guardian at any time 21 days after a previous review including a mandatory review. (See **Appendix 8: Community Treatment Orders** #13)

    A mandatory appeal occurs if the CTO is to extend beyond six months. (See **Appendix 8: Community Treatment Orders** #13)

32. Is there anything that can be done if a patient of a CTO makes themselves unavailable during the last period of a CTO?

    Answer: No. If a person leaves the province or makes themselves unavailable there is really nothing that can be done. (See **Appendix 8: Community Treatment Orders** #14)

    If the person becomes involved with the mental health system in the other province they can be returned under section 21 or 28.2. (See **Appendix 8: Community Treatment Orders** #14)

33. If a CTO expires next week but the individual is reassessed today, can the commencement date be next week's date, or must it be the date of the reassessment?

    Answer: Section 24.5(1.2) and (1.3) says that the renewal of a CTO is valid for the period specified in the CTO so there is some discretion as to indicate the date of the reassessment or the date of expiration. The term of the CTO can only be six months in length. (See **Appendix 8: Community Treatment Orders** #5,6)

34. If the CTO has not been renewed prior to its expiration date, does the person require two certificates (Form H.3 and H.4) again? What certificates are required if the CTO does not get renewed prior to its expiry, but a Form H.7 is completed prior to expiry?

    Answer: If the CTO (FormH.3) has not expired, s.24.4 says that a new certificate (H.4) is not required. If the CTO expired, then certificates H.3 and H.4 are required regardless of any other forms being completed. (See **Appendix 8: Community Treatment Orders** #5,6)

35. Do the new CTO criteria pertain only to admissions in Saskatchewan?

    Answer: The new criteria for CTOs and Long Term Detention Orders only pertain to admissions in Saskatchewan.

36. Is there a possibility of a "Charter' challenge to the changes to the criteria for CTO?

    Answer: It is not appropriate to speculate on what the courts may accept as a Charter challenge. However Alberta has adopted similar criteria and British Columbia has temporary leave provisions without a challenge.

Long Term Detention Order

37. Can a person on a Long Term Detention Order be granted temporary leave?

    Answer: Yes, under s. 29. The leave must be authorized by the attending physician indicating the benefit to the patient and detailing any restrictions who has supervisory responsibility during the leave. (Guide Chapter 5.9)

38. Long Term Detention Orders now require a total of 60 days instead of 60 consecutive days. Over what time period?

    Answer: There is no requirement that the 60 days occur within a one or two year period. The section simply states that the person has to have been detained per s. 23 or 24 for a total of 60 days or longer immediately prior to the date of application for a LTDO. (Guide Chapter 5.6)

    The phrase "immediately prior" is subject to interpretation and could be subject to review by the review panel or court. Presumably, if the person had been under a LTDO 10 years ago, this may not be considered recent enough. (Guide Chapter 5.6)

ECT

39. Does a new ECT Certificate process have to be completed when a patient is recertified at a 21 day period?

    Answer: Section 14(5) of the Regulations states that certificates issued for ECT are valid for a maximum of 12 sessions or until the expiration of any authority for the patient to be detained as an involuntary patient, whichever occurs first. So, if the Form G certificate period expires before the sessions are complete, new ECT certificates would have to be issued.

40. How can ECT be provided for Medical unit patients?

    Answer: Regions should seek legal advice from their own counsel for these individual cases. Consideration should be paid to Section 25(4) stating that no special treatment (ECT) are to be administered on an involuntary patient except in accordance with the Regulations. An involuntary patient is defined as a patient who is admitted to and detained in a Mental Health Centre per Section 23, 24 or 24.1. Thus, the ECT provisions of the *MHSA* will only apply to patients currently admitted to and detained in a Mental Health Centre.

    If the person is not admitted to and detained in a Mental Health Centre, the person is not an involuntary patient and the *MHSA* ECT provision does not apply. As such, the patient unable to consent would lead to application of *The Health Care Directives and Substitute Decision Maker's Act*. (Guide Chapter 5.11)

Prescribed Health Professionals

41. Who does the definition of Prescribed Health Professional include?

    Answer: It includes Registered Nurses, including Nurse Practitioners and Registered Psychiatric Nurses. (Guide Chapter 2 vi.)

42. Why was the Prescribed Health Professionals definition not expanded to include other groups?

    Answer: The Ministry of Health wanted to start with a small group but is willing to consider expansion in the future.

43. In the section concerning a "Prescribed Health Professional' the term reasonable amount of time is used. What does that mean?

    Answer: There is not specific definition in the Regulations. As such, discretion as to what constitutes a reasonable amount of time is left to the health professional in any given circumstance.

44. Does allowing a Prescribed Health Professional to complete a Form A contravene *The Psychologists Act, 1997*?

    Answer: The wording in section 18 has been changed so the prescribed health professional is providing an opinion and not certifying that the person has a mental disorder.

HIPA

45. How have the rules concerning the disclosure of information changed with the introduction of HIPA?

    Answer:

    i. Appendix 11 of the Guide to *The Mental Health Services Act* 2015 explains collection, use and disclosure of Personal Health Information.

    ii. *HIPA* does not apply to Approved Homes – see the Approved Homes manual.

Other questions

46. What are the implications of the amendments becoming law?

    Answer: New forms and procedures must be used from 00:01 hours of the date the amendments come into effect.

    "Old' forms may be valid but every effort must be made to use the new forms.

    Certificates that have been written before the proclamation date continue to be valid, including Form Gs, CTOs, and Long Term Detention Orders.

47. What if an involuntary patient has an advanced health care directive?

    Answer: Where a directive is made by a person subject to a certificate under section 24, 24.1 or a Community Treatment Order the directive relating to mental health treatment is used as a guide. (Guide Chapter 5.11)

48. If involuntary patients can only be admitted to a 'designated' mental health centre, what can be done in case of overcrowding when patient may stay in ED or temporary beds.

    Answer: section 18.1 provides that the director can authorize the patient's assessment, treatment or care somewhere other than the MHC, otherwise, an involuntary patient can only be admitted and be treated in an MHC. (Guide Chapter 3.1)

49. Does the change in wording to the eligibility section of the Act mean that residents of other provinces can receive services?

    Answer: No. The *Act* states that services are available to persons who are beneficiaries under *The Saskatchewan Medical Care Insurance Act*.

    Reciprocal billing arrangements for inpatient services continue.

50. Who can designate a space as a Mental Health Centre?

    Answer: The Minister of Health will have the authority to designate a Mental Health Centre pursuant to Section 10 of *The Regional Health Services Act* and in accordance with The Facility Designation Regulations. (Guide Chapter 3.1)