PRINCE EDWARD ISLAND
ÎLE-DU-PRINCE-ÉDOUARD

MENTAL HEALTH ACT REGULATIONS

PLEASE NOTE

This document, prepared by the ***Legislative Counsel Office***, is an office consolidation of this regulation, current to October 28, 2017. It is intended for information and reference purposes only.

This document is ***not*** the official version of these regulations. The regulations and the amendments printed in the ***Royal Gazette*** should be consulted on the Prince Edward Island Government web site to determine the authoritative text of these regulations.

For more information concerning the history of these regulations, please see the ***Table of Regulations*** on the Prince Edward Island Government web site (www.princeedwardisland.ca).

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MENTAL HEALTH ACT
Chapter M-6.1

REGULATIONS

Pursuant to section 43 of the *Mental Health Act* Stats. P.E.I. 1994, c. 39, Council made the following regulations:

1. Definitions

In these regulations

(a) "**Act**" means the *Mental Health Act* R.S.P.E.I. 1988, Cap. M-6.1;

(b) "**Type I facility**" means a facility designated under section 2, which may provide involuntary care;

(c) "**Type V facility**" means a facility designated under section 3, which provides chiefly voluntary care. *(EC328/96)*

2. Type I facility

(1) A Type I psychiatric facility is one which may give care to involuntary as well as voluntary psychiatric patients, and to which all provisions of the Act apply.

Designation, Type I facilities

(2) The following are designated as Type I psychiatric facilities:

(a) Hillsborough Hospital;

(b) Queen Elizabeth Hospital;

(c) Prince County Hospital. *(EC328/96; 760/05; 604/17)*

3. Type V facility

(1) A Type V psychiatric facility is one which normally provides care only to voluntary patients, although in unusual circumstances if such care is appropriate, a person may be involuntarily detained in accordance with subsection 5(5), 6(3), or section 20 or 21 of the Act.

Application of Act to Type V facilities: features definitely applying

(2) The following provisions of the Act apply to patient care in a Type V psychiatric facility:

(a) Sections 4, 5 - Patient's rights to treatment; to refuse treatment; to leave, subject to subsection 5(5);

(b) Section 31 - Confidentiality and disclosure of information in patient records;

(c) Sections 32, 33 - Patient rights to information, communication, non-discrimination;

(d) Section 41 - Protection against personal liability for officers and staff of a facility detaining a person.

***Idem*, provisions which may be applicable**

(3) The following provisions of the Act may apply as necessary to patient care in a Type V psychiatric facility:

(a) Sections 6 to 12 - Psychiatric examination and associated matters;

(b) Section 14 - Change of voluntary patient status to involuntary;

(c) Subsection 21(1) - Patient transfer to another facility;

(d) Sections 23, 24 - Consent to treatment; treatment without consent;

(e) Clause 28(2)(b) - Request to Review Board to restrict access to a patient record;

(f) Sections 34 to 38 - Offences.

***Idem*, provisions applicable for involuntary care**

(4) Any provision of the Act may apply in a Type V facility when it is necessary to control or care for a patient detained in accordance with subsection 5(5), subsection 6(3), sections 14 and 15, or sections 20 and 21 of the Act.

Designation, Type V facility

(5) An addiction treatment facility operated by Health PEI is designated as a Type V psychiatric facility. *(EC328/96; 760/05; 604/17)*

4. Transfer according to Director's protocol

When a person is to be transferred pursuant to subsection 19(3), sections 20, 21 or 22 of the Act, the transfer must be carried out following such protocols as are issued under the authority of the Director of Mental Health. *(EC328/96)*

5. Prescribed forms

The following forms are prescribed:

(a) Form 1

(a) Physician's Application for Involuntary Psychiatric Assessment

(b) Physician's Application for Involuntary Addiction Assessment

[Section 6 of the Act]

(b) Form 2

Certificate of Involuntary Admission

[Section 13 of the Act]

(c) Form 3

Reassessment by Second Psychiatrist

[Subsection 13(6) or 14(2) of the Act]

(d) Form 4

Certificate of Change of Status - Voluntary to Involuntary

[Section 14 of the Act]

(e) Form 5

Certificate of Change of Status - Involuntary to Voluntary

[Section 18 of the Act]

(f) Form 6

Certificate of Renewal
[Section 16 of the Act]

(g) Form 7

Memorandum of Transfer
[Section 21 of the Act]

(h) Form 8

Certificate of Incapacity
To Give or Refuse Consent to Treatment
[Subsection 23(4) of the Act]

(i) Form 9

Certificate of Leave
[Section 25 of the Act]

(j) Form 10

Certificate of Cancellation of Leave
[Subsection 25(3) of the Act]

(k) Form 11

Order for Return of Patient
[Section 26 of the Act]

(l) Form 12

Application to the Review Board
[Subsection 28(1), 28(2), 34(4) or 34(14) of the Act]

(m) Form 13

Certificate of Incapacity to Manage Personal Affairs
[Subsection 40(2) of the Act]

(n) Form 14

Voluntary Patient Request for Discharge
Contrary to Medical Advice
[Subsection 5(4) of the Act] *(EC328/96)*

FORM 1 (a)

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

PHYSICIAN'S APPLICATION FOR INVOLUNTARY
PSYCHIATRIC ASSESSMENT
[Section 6 of the Act]

I, ..., on ..... of ..... in ..... at .....
(*name of physician)* *(day)* *(month)* *(year)* *(hour)*

have personally completed an examination of

..... of .....
(patient's full name) *(address)*

I have made careful inquiry into the facts necessary to form an opinion as to the nature and degree of severity of this person's mental disorder. I conclude that this person:

(a) is suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the person's own safety or the safety of others; and
(b) is refusing or is unable to consent to undergo psychiatric assessment.

I therefore apply for a psychiatric assessment under subsection 6(1) of the *Mental Health Act*.

REASONS FOR THE APPLICATION

Findings of examination/Physician's own observations:

Information from other sources in support of this application *(specify sources)*:

I believe there are no medical reasons that contraindicate movement, and therefore request that this person be taken to **.....** for involuntary psychiatric assessment. *(facility)*

Date: ..... Physician's Signature: .....

- Form 1 is completed when safety (to the patient and/or others) is a major concern, and the patient does not or cannot consent to assessment by a psychiatrist. Safety risk may be indicated, for example, by threats to inflict harm on oneself or aggressive behaviour towards others.
- This application authorizes that, within 7 days, the patient may be taken into custody, taken to a designated psychiatric facility, and held there (maximum 72 hours) for assessment by a psychiatrist.
- This form is sent, accompanying the patient, to the facility where the patient is assessed.

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 1 (b)

PHYSICIAN'S APPLICATION FOR INVOLUNTARY
ADDICTION ASSESSMENT
[Section 6 of the Act]

I, ..., on ..... of ..... in ..... at .....
(*name of physician)* *(day)* *(month)* *(year)* *(hour)*

have personally completed an examination of

..... of .....
(patient's full name) *(address)*

I have made careful inquiry into the facts necessary to form an opinion as to the nature and degree of severity of this person's mental disorder. I conclude that this person:

(a) is suffering from a mental disorder, resulting from alcohol or drug addiction or abuse, of a nature or degree so as to require hospitalization in the interests of the person's own safety or the safety of others; and

(b) is refusing or is unable to consent to undergo addiction assessment.

I therefore apply for a addiction assessment under subsection 6(1) of the *Mental Health Act*.

REASONS FOR THE APPLICATION

Findings of examination/Physician's own observations:

Information from other sources in support of this application *(specify sources)*:

I believe there are no medical reasons that contraindicate movement, and therefore request that this person be taken to ..... for involuntary addiction assessment. *(facility)*

Date: ..... Physician's Signature: .....

- Form 1 is completed when safety (to the patient and/or others) is a major concern, and the patient does not or cannot consent to assessment by a medical addiction consultant. Safety risk may be indicated, for example, by threats to inflict harm on oneself or aggressive behaviour towards others.
- This application authorizes that, within 7 days, the patient may be taken into custody, taken to a designated psychiatric or addiction treatment facility, and held there (maximum 72 hours) for assessment.
- This form is sent, accompanying the patient, to the facility where the patient is assessed.

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 2

CERTIFICATE OF INVOLUNTARY ADMISSION

[Section 13 of the Act]

I, ..., on ..... of ..... in ..... at .....
(*name of psychiatrist)* *(day)* *(month)* *(year)* *(hour)*

have personally completed a psychiatric assessment of

..... of .....
(patient's full name) *(address)*

As a result of the assessment I have reached the conclusion that this person

(a) is suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the person's own safety or the safety of others; and

(b) is refusing or is unable to consent to voluntary admission.

I therefore admit, or confirm admission of, this person to ..... *(facility)*..... as an involuntary patient under section 13 of the *Mental Health Act*.

REASONS FOR INVOLUNTARY ADMISSION

Findings from assessment/Psychiatrist's own observations:

Information from other sources in support of this certificate *(specify sources)*:

Summary of the nature and degree of severity of the person's mental disorder:

Diagnosis or Provisional diagnosis:

Unless cancelled, this certificate is valid until ..... *(maximum 28 days)*

Date: ..... Psychiatrist's Signature: .....

I ☐ was/ was not ☐ the physician who made the examination of the patient under section 6. If so, the patient or representative may request a reassessment by another psychiatrist [s. 13(6)].

- This certificate is to be filed with the Administrator of the facility.
- The Administrator is responsible to notify the most immediately available family member or person who has a close relationship with the patient or the designated public guardianship official [s. 17(2)].

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 3

REASSESSMENT BY SECOND PSYCHIATRIST

[Subsection 13(6) or 14(2) of the Act]

I, ..., on ..... of ..... in ..... at .....
(*name of psychiatrist)* *(day)* *(month)* *(year)* *(hour)*

have personally completed a psychiatric reassessment of

..... of .....
(patient's full name) *(address)*

I conclude that this person does | /does not | meet the criteria for involuntary admission/status:

(a) suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the person's own safety or the safety of others; and
(b) refusing or unable to consent to voluntary admission. [Subsection 13(1) of the Act]

I therefore

~ confirm the involuntary admission/status of this person

~ determine that this person continue hospitalization as a voluntary patient pursuant to s. 13(2)

~ determine that this person be released pursuant to s. 13(3)

REASONS

Findings from assessment/Psychiatrist's own observations:

Information from other sources in support of this certificate *(specify sources)*:

Summary of the nature and degree of severity of the person's mental disorder:

Diagnosis or Provisional diagnosis:

Date: ..... Psychiatrist's Signature: .....

•This certificate is to be filed with the Administrator of the facility.

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 4

CERTIFICATE OF CHANGE OF STATUS
VOLUNTARY TO INVOLUNTARY
[Section 14 of the Act]

I, ...,on ..... of ..... in ..... at .....
(*attending psychiatrist)* *(day)* *(month)* *(year)* *(hour)*

have examined and assessed the mental condition of voluntary patient

..... of .....
(patient's full name) *(address)*

I conclude that this person now meets the criteria for involuntary admission [s. 13(1) of the Act]:

(a) suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the person's own safety or the safety of others; and
(b) refusing or unable to consent to voluntary admission.

I therefore change this person's status from voluntary to involuntary.

REASONS

Findings from assessment/Psychiatrist's own observations:

Information from other sources in support of this certificate *(specify sources)*:

Summary of the nature and degree of severity of the person's mental disorder:

Diagnosis or Provisional diagnosis:

Unless cancelled, this certificate is valid until.....*(maximum 28 days)*

Date: ..... Psychiatrist's Signature: .....

- This certificate is to be filed with the Administrator of the facility.
- The Administrator is responsible to notify the most immediately available family member or person who has a close relationship with the patient or the designated public guardianship official [s. 17(2)].
- The patient or representative may request a reassessment by another psychiatrist [s. 14(2)].

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 5

CERTIFICATE OF CHANGE OF STATUS
INVOLUNTARY TO VOLUNTARY
[Section 18 of the Act]

I, ..., on ..... of ..... in ..... at .....
(attending psychiatrist) *(day)* *(month)* *(year)* *(hour)*

have completed a reassessment of involuntary patient

..... of .....
(patient's full name) *(address)*

I believe that the prerequisites for involuntary admission [s. 13(1)] are no longer met. Rather I believe that the prerequisites for admission as a voluntary patient [s. 13(2)] are met:

(a) suffering from mental disorder;
(b) in need of the psychiatric treatment provided in a psychiatric facility;
(c) suitable for admission as a voluntary patient; and
(d) consenting to be admitted as a voluntary patient.

I therefore change this person's status from involuntary to voluntary.

Notes/Comment: .....

Date: ..... Psychiatrist's Signature: .....

- This certificate is to be filed with the Administrator of the facility.
- The Administrator must see that the patient is promptly informed of voluntary status and the right to leave.

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 6

CERTIFICATE OF RENEWAL

[Section 16 of the Act]

I, ..., on ..... of ..... in .....
(*attending psychiatrist)* *(day)* *(month)* *(year)*

have completed a reassessment of involuntary patient

..... of .....
(patient's full name) *(address)*

I find that the prerequisites for admission as an involuntary patient [s. 13(1)] continue to be met:

(a) suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the person's own safety or the safety of others; and
(b) refusing or unable to consent to voluntary admission.

I therefore renew this person's status as an involuntary patient.

REASONS

Findings from assessment/Physician's own observations:

Information from other sources in support of this certificate *(specify sources)*:

Summary of the nature and degree of severity of the person's mental disorder:

Diagnosis or Provisional diagnosis:

This certificate expires on ..... (unless cancelled earlier). It is for a

☐ first renewal (maximum 30 days) ☐ second renewal (maximum 90 days)
☐ third renewal (maximum of 90 days) ☐ renewal (maximum of 12 months)

Date: ..... Psychiatrist's Signature: .....

- This certificate is to be filed with the Administrator of the facility.
- The Administrator is responsible to notify the most immediately available family member or person who has a close relationship with the patient or the designated public guardianship official [s. 17(2)].
- Review Board must review the patient's status on the filing of a third certificate and annually thereafter [16(4)]

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 7

MEMORANDUM OF TRANSFER

[Section 21 of the Act]

On the advice of the attending psychiatrist, and having made the necessary arrangements,

I, ... Administrator of .....
(*name of administrator)* *(name of facility)*

hereby transfer

..... of .....
(patient's full name) *(home address)*

to .....
(*destination facility*)

Any authority to detain will continue, but will now lie with the destination facility.

Explanation/Comments:

• The status of this patient is ☐voluntary/involuntary ☐
• This patient
☐ does not have ...
☐ has a substitute decision-maker for consent to treatment [s. 23(6) or (8)]

.....
(*name*)

• This patient
☐ does not have ...
☐ has an appointed guardian .....
(*name*)

• This patient
☐ does not have ...
☐ has an appointed trustee
to manage estate matters .....
(*name*)

Date: ..... Administrator's Signature.....

- To be sent to destination facility
- Copy to be retained by transferring facility

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 8

CERTIFICATE OF INCAPACITY
TO GIVE OR REFUSE CONSENT TO TREATMENT
[Subsection 23(4) of the Act]

I, ..., on ..... of ..... in .....
(*attending psychiatrist)* *(day)* *(month)* *(year)*

have considered the capacity to give or refuse consent of

..... of .....
(patient's full name) *(address)*

In accordance with subsection 23(3) of the Act, I have considered

(a) whether the patient understands
  (i) the condition for which the treatment or course of treatment is proposed,
  (ii) the nature and purpose of the treatment or course of treatment,
  (iii) the risks and benefits involved in undergoing the treatment or course of treatment,
  (iv) the risks and benefits involved in not undergoing the treatment or course of treatment;
(b) whether the patient's ability to consent is affected by his or her condition.

I believe that the patient is incapable of making a decision to give or refuse consent to treatment.

Comments:.....

SUBSTITUTE DECISION-MAKER

In accordance with subsection 23(6), the person (guardian, most appropriate family member or other person having a close relationship) who may give or refuse consent to treatment on the patient's behalf is

.....
(*name of substitute decision-maker)*

Alternative: In accordance with subsections 23(7) and (8), the public official having the duty of public guardianship is hereby authorized to be the patient's substitute decision-maker |

Date: ..... Psychiatrist's Signature: .....

CANCELLATION

The patient's capacity to consent must be reviewed before
.....,
(*date one month from date of this certificate*)
and at least monthly thereafter. Where the attending psychiatrist is satisfied by such review that it is appropriate, this certificate of incapacity is to be cancelled [s. 23(10)].

| This certificate is cancelled ....
(*date*) (*signature of attending psychiatrist*)

- This certificate is to be filed with the Administrator.
- The Administrator must provide a copy to the patient and to the most immediately available family member or other person with a close relationship with the patient, and notify them in writing of the right to apply to the Review Board for a review of the psychiatrist's opinion. It may be necessary to send a copy to the designated public guardianship official [s. 23(7)].
- When cancelling the certificate the attending psychiatrist must notify the Administrator, the patient and substitute decision-maker or public guardianship official.

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 9

CERTIFICATE OF LEAVE

[Section 25 of the Act]

I,....., the attending psychiatrist, authorize

(name of psychiatrist)

..... ,

(*name of patient)*

an involuntary patient at ....., to live outside the facility.

(facility)

This certificate of leave is subject to the following conditions.

• The patient must report for monitoring/treatment as follows (time, frequency, place, contact, etc.):

• Further conditions:

.....

.....

.....

.....

.....

.....

• This certificate is valid (unless cancelled earlier by a Certificate of cancellation of leave)

☐ until expiry of the certificate of admission, renewal or change to status by which the patient's involuntary status is established:.....

(*date of expiry of certificate of involuntary status)*

or

☐ until

(other chosen expiry date)

Date: ..... Psychiatrist's Signature: .....

PATIENT'S CONSENT

• I consent to this certificate of leave and agree to the specified conditions.

• I understand that failure to report as required or to follow any other of the conditions may result in cancellation of this certificate.

• I understand that I may be returned to this institution if my condition presents a danger to myself or others.

• I understand that I continue to be an involuntary patient until such time as my certificate of involuntary admission (or renewal or change to involuntary status) expires or is cancelled.

Date: ..... Patient's Signature:.....

• This certificate is to be filed with the Administrator. • A copy is to be given to the patient.

• A Certificate of leave may be cancelled by issuance of a Certificate of cancellation of leave.

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 10

CERTIFICATE OF CANCELLATION OF LEAVE
[Subsection 25(3) of the Act]

I,....., the attending psychiatrist, cancel the
(name of psychiatrist)
Certificate of leave issued ..... for ..... .
(date of certificate) *(name of patient)*

I believe

- ☐ the patient's condition may present a danger to the patient or others
- ☐ the patient has failed to report as required by the certificate of leave
- ☐ the patient has not followed the further conditions set by the certificate of leave

The person is to return as an involuntary patient to .....
(*facility*)
This certificate authorizes a peace officer to take the patient into custody and back to the facility.

Date: ..... Psychiatrist's Signature:.....

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 11

ORDER FOR RETURN OF PATIENT
[Section 26 of the Act]
TO: All Peace Officers in the province of Prince Edward Island

I, ..., administrator of ..... ,
(*name of administrator*) (*facility*)
authorize that the patient named in this order be taken into custody and returned to this facility.
This person is an involuntary patient at this facility, and is absent from it without the permission of the attending psychiatrist .....
(*name of psychiatrist)*
The patient has apparently been absent since .....
(*date/time of day of leaving the facility*)
Name of patient: .....
Home Address: .....
Description of patient:

Date: ..... Administrator's Signature: .....
Contact telephone: .....

- This order authorizes any peace officer to take the named patient into custody and take him/her to the facility.
- The order is valid for up to 30 days from the date of issue.

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 12

APPLICATION TO THE REVIEW BOARD
[Subsection 24(1), 28(1), 28(2), 31(4) or 31(14) of the Act]

Concerning ..... , a patient
(*patient's name)*
admitted to ..... on the ..... of ..... , ...
(*facility*) (*day*) (*month*) (*year*)

This application is made to the Review Board by .....
(*name of applicant*)

Relationship of the applicant to the case:

☐ the patient ☐ legal counsel ☐ parent(s)
☐ guardian ☐ substitute decision-maker ☐ other representative
☐ administrator of facility ☐ attending psychiatrist ☐ Director of Mental Health
☐ other

This application asks the Review Board to consider and make a decision regarding:

☐ involuntary admission ☐ patient's status
☐ certificate of renewal ☐ certificate of leave
☐ certificate of incapacity-consent ☐ choice of substitute decision-maker
☐ capability to manage own affairs ☐ inter-facility transfer
☐ interjurisdictional transfer ☐ communication rights
☐ authorization of treatment without consent ☐ withholding of clinical record

Brief description of the issue and the applicant's request:

The applicant may provide further explanation on attached pages, and may attach or refer to other documents which the applicant wishes the Review Board to take into account.

Date: .....Applicant's Signature: .....

- The Review Board must hold a hearing and make a decision within 10 days of receiving this application.
- The Board must give 3 days notice of the hearing to all parties - applicant, patient, administrator; possibly the substitute decision-maker; and any other person the Board may wish to add as having a substantial interest in the case.

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 13

CERTIFICATE OF INCAPACITY TO MANAGE PERSONAL AFFAIRS
[Subsection 40(2) of the Act]

I, ...……..., on ..... of ..... in .....
(*name of physician)* *(day)* *(month)* *(year)*

have personally completed an examination of

.....……..……..... of .....
(patient's full name) *(address)*

I find that this person is, on a continual or habitual basis, not able to

(a) understand information that is relevant to making decisions;

(b) make or effectively communicate reliable decisions which are necessary for his or her health care, nutrition, accommodation, clothing, hygiene, welfare or other matter essential for ordinary life; and

(c) appreciate the reasonably foreseeable consequences of such decision or lack of decision.

My opinion, therefore, is that this person is incapable of managing his or her personal affairs.

Personal affairs means such matters as residence, health care, legal proceedings, education/training, social contact.

Note that estate matters (property and financial) are addressed under the *Public Trustee Act.*

Information/explanation/comment:

Date:..... Physician's Signature: .....

- Two of these certificates of incapacity, each completed by a physician, must accompany an application for guardianship under section 40 of the *Mental Health Act*.

PRINCE EDWARD ISLAND MENTAL HEALTH ACT

FORM 14

VOLUNTARY PATIENT REQUEST FOR DISCHARGE
CONTRARY TO MEDICAL ADVICE
[Subsection 5(4) of the Act]

I,....., of .....
(patient's full name) *(address)*

a voluntary patient in....., request that I be discharged.
(name of facility)

☐ I make this request even though I have been advised by the person(s) responsible for my medical care that I should not leave the facility.

☐ I am aware that the treatment staff of the facility have a responsibility to detain me for a psychiatric examination if there are reasonable grounds to believe that I am

(a) suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of my own safety or the safety of others; and
(b) refusing to undergo psychiatric examination.

Patient's Signature: .....

Date: .....Time: ..... Witness: .....

• To be filed in the patient's clinical record