Province of British Columbia

Ministry of Health

Mental Health Act, R.S.B.C. c 1996, c.288

Standards for Operators and Directors of Designated Mental Health Facilities

December 9, 2020

TABLE OF CONTENTS

INTRODUCTION

These standards have been prepared to respond to recommendations made by the Ombudsperson of British Columbia following a review of involuntary admissions practices in designated mental health facilities, which culminated in the publication of *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act*).[1] In that report the Ombudsperson recommended that "the Ministry of Health and the Ministry of Mental Health and Addictions work together with the health authorities to establish clear and consistent provincial standards aimed at achieving 100 percent compliance with the involuntary admission procedures under the *Mental Health Act* through the timely and appropriate completion of all forms."[2]

Following the Ombudsperson report, these standards were developed in collaboration with leaders and experts across British Columbia in mental health and substance use policy, practice and service delivery. The process involved establishing a Provincial Advisory Committee (PAC) and related subcommittees. Observation of and participation in health authorities' *Mental Health Act* working groups, and individual consultations with representatives from each operator of a designated mental health facility as well as relevant community services took place throughout the process.

The PAC and subcommittees met from spring through fall 2019 to guide the identification of issues for inclusion in these standards. Due to the scope, focus and timelines determined by the Ombudsperson's recommendations for changes in applying the *Mental Health Act,* these standards prioritized discussion, consultation and collaboration around standards for forms 4, 5, 13, 14, 15 and 16, as well as the standards on education and accountability. The first phase also included specific consultation and collaboration with the First Nations Health Authority and other stakeholders around cultural safety. Input from the Mental Health Review Board regarding forms 7 and 8 has also been incorporated into this document.

The standards and the accompanying narrative descriptions of the Act, Regulation and forms set out in this document are intended to outline the expected conduct of the key actors involved in administering the *Mental Health Act*. These key actors include organizations that operate designated mental health facilities (primarily health authorities), directors of designated mental health facilities, and clinicians (primarily, but not solely, **physicians**). The purpose of the standards is to ensure that all the key actors under the Act know what is expected of them when administering the Act and so that in turn the Ministries can be assured that the Act is being administered correctly and consistently across British Columbia's designated facilities.

[1] Office of the Ombudsperson (2019), *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act*, Special Report No. 42, p. 36. Retrieved from https://bcombudsperson.ca/sites/default/files/OMB-Committed-to-Change-FINAL-web.pdf

[2] Office of the Ombudsperson (2019), p. 77.

In addition, the PAC and subcommittee process identified many points of challenge respecting the administration of BC's *Mental Health Act*, which merit further exploration or clarification. Work will continue to improve, refine and finalize these standards by spring 2020, and will include consultations with people with lived experience of admission under the Act.

Once finalized, compliance with these standards will be assessed using performance and patient-report measures according to the Ministry of Mental Health and Addictions' "British Columbia *Mental Health Act* Quality Improvement Framework: Involuntary Admissions."

This document makes a number of references to the publication Guide to the *Mental Health Act* (2005) (the "Guide"). It is the intention of the Ministry that the Guide will be updated by September 2020.

This document is not intended to be a substitute for legal advice, nor does it address the application of related legislation such as the *Health Care (Consent) and Care Facility (Admission) Act, Infants Act, Adult Guardianship Act* and *Child,* and *Family and Community Service Act*.

POWER OF THE MINISTER(S) TO MAKE STANDARDS

The Minister of Health is responsible for the *Health Authorities Act* generally, and additionally, both the Minister of Health and the Minister of Mental Health and Addictions share the authority to make standards by policy, and in the form of Regulations made pursuant to section 3 of *the Health Authorities Act* as they relate to mental health.

The *Mental Health Act* is assigned to the Minister of Health and as such, the Minister has a superintendent role respecting the administration of the Act by the key actors. Consistent with this superintendent role, the Minister may establish and publish policy guidance to be applied by the key actors. Additionally, the Minister of Health has express authority to make standards in the form of orders and directives, which must be observed by a director in charge of a Provincial mental health facility.[3]

TERMINOLOGY

A reference in this document to the "Act" means the *Mental Health Act*, R.S.B.C 1996 c.288.

A reference in this document to the "Regulation" means the Mental Health Regulation, B.C. Reg. 233/99. Key words and phrases which are **bolded** in this document are defined in the *Mental Health Act* and the Mental Health Regulation, and have the same meaning in this document as in the Act and Regulation. For convenience, those definitions are set out in the Glossary attached to this document.

Additionally, in this document, the following words and phrases have the following meaning:

- **Operators:** The phrase "operators" is used throughout this document and is intended to refer to the organization that owns and operates the designated facility. In most cases, this will be a regional

[3] *Mental Health Act*, R.S.B.C. 1996, Chapter 288, Section 8. Retrieved from http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96288_01.

health authority. Additionally, Providence Health Care Society, Community Living British Columbia, the Ministry of Children and Family Development and the Correctional Service of Canada also operate designated facilities.

- **Staff:** The phrase "staff" is not used in the *Mental Health Act*. Where it appears in this document, it is intended to refer to persons working as employees in the **designated facility** but does not include the **director** or **physicians**.

STANDARD ONE – ENHANCED ACCOUNTABILITY

BACKGROUND

The phrase "**director**" is defined in the Act:

> **"director"** means a person appointed under the regulations to be in charge of a designated facility and includes a person authorized by a director to exercise a power or carry out a duty conferred or imposed on the director under this Act or the *Patients Property Act*;

The Regulation provides that the the health authority responsible for the operation of a designated facility must appoint a person as **director** of the facility.[4]

The powers and duties of the director include the matters set out in section 8 and section 18:

Powers and duties of directors

8 A director must ensure

(a) that each patient admitted to the designated facility is provided with professional service, care and treatment appropriate to the patient's condition and appropriate to the function of the designated facility and, for those purposes, a director may sign consent to treatment forms for a patient detained under section 22, 28, 29, 30 or 42,

(b) that standards appropriate to the function of the designated facility are established and maintained, and

(c) if in charge of a Provincial mental health facility, that the orders and directives of the minister are observed and performed.

When persons are not to be admitted

18 Despite anything in this Act, a director or person who has authority to admit persons to a Provincial mental health facility must not admit a person to a Provincial mental health facility if

(a) suitable accommodation is not available within the Provincial mental health facility for the care, treatment and maintenance of the patient, or

(b) in the opinion of the director or person who has authority to admit persons to the Provincial mental health facility, the person is not a person with a mental disorder or is a

[4] *Mental Health Act,* Mental Health Regulation 233/99, Section 3. Retrieved from http://www.bclaws.ca/civix/document/id/complete/statreg/233_99.

person who, because of the nature of his or her mental disorder, could not be cared for or treated appropriately in the facility.

It is the position of the Province that compliance with the procedures delineated in the *Mental Health Act*, including timely and appropriate completion of all forms, is required. As the Ombudsperson's report states, the forms "are not just paperwork. They provide the legal authority for an involuntary admission and detention, and, when properly completed, provide evidence that facilities are safeguarding patients' constitutional rights in the admissions process."[5] Furthermore, compliance with all statutory procedures, including completion of forms, promotes patient engagement and recovery by increasing patients' sense of being treated fairly, even when they are involuntarily admitted and if compelled to accept psychiatric treatment.[6] In this respect, compliance with the procedures in the Act will also ensure that patients clearly understand their status under the Act and in particular the reasons for the decisions that have an impact on them.

It is important to note that these standards respecting the role of the **director** have been established to clarify the duties and powers of the **director** under the Act. In this regard, these new standards establish some limits on the authority of the **director** to authorize another person to exercise the director's authority (i.e., to delegate authority to another person). These standards provide that a physician who has been delegated the authority to act as the director must not also be the physician who signs the medical certificate, nor may they be the physician recommending treatment for the patient.

STANDARDS

Operators of designated facilities shall ensure that:

- All policies and procedures in support of the involuntary admissions provisions of the Act and established by the operator are consistent with the Act, the Regulation and these standards.
- The principles of culturally safe, trauma-informed, recovery oriented, least restrictive practice are followed with the aim of ensuring that every effort shall be made to prevent the need for an involuntary admission.
- Access to interpreters and other supports are reasonably available for patients for whom English is not a first language or for whom literacy is a barrier to comprehension and who require support to read and understand information provided to patients about their admission.
- For each patient the designated facility accurately records when a period of involuntary admission begins and ends and the name of the person exercising the authority as **director** to admit the patient.

[5] Office of the Ombudsperson (2019), p. 36.
[6] Iva W. Cheung (2019), *Improving Patients' Understanding of Their Rights under British Columbia's Mental Health Act* (Doctoral dissertation, Simon Fraser University, Faculty of Health Sciences), 32 and 12. Retrieved from https://theses.lib.sfu.ca/5346/show.

- A practice is established whereby specific staff are assigned the responsibility, in each **designated facility**, to review each form for timeliness and completion in accordance with these standards, before the form is placed in a patient's chart.
- The approval of the Ministry of Health is received, prior to implementation, of policies and procedures, allowing Forms required under the Mental Health Act to be signed electronically.
- A senior official within the health authority is appointed by the board of the health authority to maintain a current list of all appointed directors within the health region and to oversee the performance of all appointed directors and persons authorized by an appointed director to perform the duties of the appointed director,

With respect to the appointment of directors, operators shall ensure that:

- A **director** is appointed, in writing, by the operator for each **designated facility** (the "Appointed Director").
- If a physician is appointed as a director, the physician shall be a salaried employee of the operator.
- Before appointing a person as a **director,** the operator must be satisfied that the person to be appointed is familiar with the powers and duties of the **director** set out in the Act, Regulations, the *Guide to the Mental Health Act* (2005) (the "Guide"), and these standards.
- A list of Appointed Directors is maintained by the operator and made available to the ministry, on request.
- Policies are in place to ensure that any **physician** authorized by an Appointed Director:
    - to admit patients involuntarily on the basis of a medical certificate[7] (section 22) is not also the physician who completes a medical certificate for the purpose of section 22 for a patient;
    - to act as the director for the purpose of section 31[8] (deemed consent to treatment and request for a second opinion) is not also the **physician** who is recommending treatment for the patient; and
    - does not purport to further authorize other persons to act on behalf of the director.

Appointed Directors – limits on authority to authorize other persons to act on their behalf:

- Before authorizing another person to exercise any authority of the Appointed Director, the Appointed Director must be satisfied that the other person is familiar with the powers and duties of **directors** set out in the Act, Regulations, the *Guide to the Mental Health Act* (2005) (the "Guide"), and these standards.
- The Appointed Director may only authorize another person to exercise the powers of the Appointed Director, if the other person is a salaried employee of the operator.
- The authorization of another person, or persons, by the Appointed Director, to exercise the powers of the Appointed Director, must be in writing, name the individual or position title and specify the duration of the authorization.

[7] FORM 4
[8] FORM 5

- An Appointed Director may only authorize another person to exercise the authority of the **director** if the other person:
    - is an employee of the operator with senior authority for patient care in the facility and is a registrant in good standing of a regulated health profession, or
    - if a physician, has been granted privileges to admit patients to mental health facilities operated by the operator, or
    - if the physician is a physician in community and the authorization of the director expressly names the community physician.

STANDARD TWO – AUDITING AND REPORTING

BACKGROUND

The purpose of these standards is to ensure that the Government of British Columbia has evidence that the involuntary admission and **treatment** of patients admitted under *the Mental Health Act* is being carried out in accordance with the Act and common and consistent administrative procedures established in this document.

Compliance auditing reported to the Ministry of Health will be undertaken at regular intervals based on these standards.

- The results of compliance audits based on the standards will be reported annually to the public.
- Compliance with the standards respecting completion of forms will be an annual performance measure for each health authority.
- A 100 percent rate of compliance with the standards for forms completion for involuntary admissions will be an annual performance measure for the chief executive officer of each operator of a **designated facility**.
- Compliance reports will be uprepared using the criteria set out in the Audit Standards, set out as Appendix 1, to this document.

STANDARDS

Operators shall:

- Facilitate auditing and compliance monitoring with these standards by managing records for patients admitted involuntarily according to established best practices, and ensuring that all Mental Health Act forms are stored in an electronic database that makes them readily accessible for the purpose of compliance monitoring.
- Ensure that the results of audits for both completion and quality are:
  - Anonymized so that it is not possible to identify any specific health care provider, employee or patient.
  - Summarized and provided to **directors, physicians** and all staff.
  - Presented with recommendations for quality improvement for all **physicians** and staff where shortcomings are identified.

STANDARD THREE – CULTURAL SAFETY AND HUMILITY

BACKGROUND

According to BC's First Nations Health Authority (FNHA): "**Cultural safety** is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving care." **Cultural humility** is a method for achieving cultural safety. It is "a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience."[9]

Delivering care that is culturally safe is vital for work with Indigenous people, and at the core of the Declaration of Commitment signed by BC's Ministry of Health and Ministry of Mental Health and Addictions, and the health authorities. These standards provide requirements for delivering culturally safe services to all Indigenous people admitted under the Act.

In this context, these standards emphasize the centrality of trauma-informed practice to achieving cultural safety. Trauma-informed practice takes into account health care providers' understanding of trauma in all aspects of service delivery. Trauma-informed practice is supported, in part, through awareness among providers of the wide-ranging impacts of trauma on individuals and communities, both direct and intergenerational. This includes the ways in which trauma changes an individual's neurobiology and capacity for adaptive social functioning and emotional regulation. Most individuals hospitalized for major mental illness have a history of trauma. For more information, consult BC's Trauma-Informed Practice Guide (2013) and Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families (2016).

STANDARDS

Operators of designated facilities shall:

- Make all directors, staff and **physicians** aware of the British Columbia's Declaration of Commitment (2015) to advance cultural safety and humility within health services.
- Support all directors, staff and **physicians** to practice from a place of cultural humility.
- Ensure services are delivered to Indigenous patients in a manner that supports traditional ways of knowing, and values connections between humans and the spiritual and natural worlds.

[9] First Nations Health Authority (2015), *#itstartswithme Creating a Climate for Change: Cultural Safety and Humility in Health Services Delivery for First Nations and Aboriginal Peoples in British Columbia.* Retrieved from http://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf

- Endeavour to make San'yas Indigenous cultural safety training or other cultural safety training[10] available to all **directors**, **physicians** and staff exercising authority under the *Act*.
- Ensure that Indigenous patients have reasonable access to resources including Indigenous/Aboriginal patient liaisons/navigators, traditional healers and Elders, etc.

Directors shall ensure:

- Admissions under the *Mental Health Act* are undertaken in a manner that is culturally safe and appropriate.
- A patient who self-identifies as Indigenous is connected with the operator's resources for Indigenous/Aboriginal patient liaisons/navigators, traditional healers, and/or Elders, and that this connection is offered and ideally occurs within 24 hours of the involuntary admission.
- Indigenous patients have access to interpreters if they do not speak English fluently, and are supported to read and understand information provided about their admission.

[10] Such training may be provided by regional health authorities, local First Nations or other Indigenous bodies.

STANDARD FOUR – TRAINING AND EDUCATION

BACKGROUND

From the *Guide to the Mental Health Act* (2005):

> The main purpose of the Mental Health Act is to provide authority, criteria and procedures for involuntary admission and **treatment**. However, the Act also contains protections to ensure that these provisions are applied in an appropriate and lawful manner. Safeguards for the rights of people involuntarily admitted to a psychiatric facility include rights notification, medical examinations at specific time periods, second medical opinions on proposed **treatment** and access to review panels and the court.[11]

Because the Act includes procedural protections, it is important that people involved in engaging the powers of the Act have a clear and comprehensive understanding of the legal scheme within which they are providing services. As such, the Province wishes to ensure that **directors**, **physicians** and staff responsible for providing care under the *Mental Health Act* are trained to apply the *Act* in accordance with the statutory scheme and these standards. It is the intention of the Province that having received training, all key actors will demonstrate improvement in the quality of the involuntary admissions process, particularly around completion of Medical Certificates (Form 4), consent to **treatmen**t forms (Form 5), and notification of rights processes (Form 13).

STANDARDS

Operators shall ensure that:

- All **directors**, physicians and staff who are regularly and actively involved in the admission and **treatment** of patients under the *Mental Health Act* have completed provincially approved education regarding admissions under the *Mental Health Act* and are familiar with the *Guide to the Mental Health Act* and these standards.
- In addition to the above, for facilities that provide services to specific patient populations (such as children and youth, geriatric, forensic and developmental disabilities), the operator shall provide supplemental training to **directors, physicians** and staff.
- A written record is maintained of the persons who have completed the required training.
- Any training provided by the operator regarding the *Mental Health Act* is approved by the province.

[11] *Guide to the Mental Health Act* (2005 Edition). Retrieved from https://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf.

STANDARD FIVE – PROTOCOLS WITH POLICE AGENCIES

BACKGROUND

Police are often first responders in helping individuals experiencing a mental health crisis: "Individuals with MHSU issues within BC are increasingly interfacing with police agencies. There is a need throughout BC for integrated and collaborative approaches between police agencies and health authorities to better meet the needs of people with MHSU issues and their families."[12]

The *Mental Health Act* addresses the circumstances under which police may intervene.

Section 28(1) of the Act provides:

Emergency procedures

> **28** (1) A police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person
> (a) is acting in a manner likely to endanger that person's own safety or the safety of others, and
> (b) is apparently a person with a mental disorder.

The *Guide to the Mental Health Act* (2005) provides:

> ***When Can Police Intervene?***
>
> If it is not possible for a person who apparently has a mental disorder to see a physician, the Act authorizes the police to intervene in some circumstances.
>
> Police Involvement with people with mental disorders can arise from complaints about the person by others, direct observation of the person's behavior by the police or in response to requests for assistance form health professionals or family members. There is no need for the person to have committed a criminal offence before the police can be involved under the Mental Health Act.
>
> Requests for police assistance often involve emergency or urgent situations where the usual procedures of seeing a physician or going to the hospital are not possible.

In 2018, the Canadian Mental Health Association BC Division on behalf of the British Columbia Ministries of Health and Public Safety and Solicitor General established a toolkit, *Interfaces Between Mental Health*

[12] Canadian Mental Health Association BC Division (2018), *Interfaces Between Mental Health and Substance Use Services and Police*. Developed on behalf of the Ministry of health, Ministry of Public Safety and Solicitor General. Retrieved from https://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/police-interface-report.pdf.

and Substance Use Services and Police (the "Toolkit"), to guide police agencies and health authorities in working together to address the needs of people with mental health and/or substance use issues.[13]

STANDARDS

Operators shall:

- Work with police to develop a protocol that includes a clear description of the process for transferring responsibility for a patient from police to the director of the designated facility.
- In accordance with the guidance in the Toolkit, develop protocols with local police departments or the local RCMP which clearly document expectations for how police and emergency departments will respond when a patient seeking care for a mental health disorder leaves the emergency department unexpectedly.
- Ensure ongoing collaboration with local police agencies to ensure that people requiring apprehension and transport to a designated facility under the *Mental Health Act* are treated in accordance with police-MHSU service protocols and these provincial standards and guidelines.

[13] Canadian Mental Health Association BC Division (2018).

STANDARD SIX – REQUIREMENTS FOR THE COMPLETION OF FORMS (4, 5, 13, 14, 15 AND 16)

BACKGROUND:

From the *Guide to the Mental Health Act* (2005):

> One Medical Certificate (Form 4) is required to provide legal authority for an involuntary admission for a 48-hour period. A Medical Certificate is completed by a **physician** who examines a person and finds that the person meets the involuntary admission of the *Mental Health Act* (Section 22(3)).
>
> The complete Medical Certificate provides authority for anyone, including ambulance personnel, police or if the **physician** believes it is safe, relatives or other to take the person to a **designated facility**. With the approval of the **director** or designate, the person may be admitted for up to 48 hours.

For a physician to fill out a Medical Certificate, the physician must have examined the patient and be of the opinion that the patient meets ALL four of the criteria. The opinion must be based upon information from the examination and preferably includes information received from family members, health care providers or others involved with the person. The criteria are that the patient:

- is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others;
- requires psychiatric **treatment** in or through a **designated facility**;
- requires care, supervision and control in or through a **designated facility** to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others; and
- is not suitable as a voluntary patient.

Alternatives to involuntary admission should be explored during this phase, and involuntary admission pursued only if the patient cannot suitably be admitted on a voluntary basis.

STANDARDS

Operators of designated facilities shall ensure that:

- All designated facilities provide a comfortable, non-threatening environment for patient assessments.

- All staff in acute psychiatric units and emergency departments collaborate so that people presenting to the emergency department with a mental health problem are seen in a timely manner depending on the patient's assessed level of acuity.
- When a patient is brought to the **designated facility** for assessment and examination for the purpose of preparing the first Medical Certificate, the examination is performed as soon as possible upon the person's arrival, and ideally within two hours.
- An examination of the person who is brought to the **designated facility** is undertaken by a medical practitioner, in person whenever possible. In rural and remote locations or when geography poses a barrier to timely access to a medical practitioner, the examination of the person by the medical practitioner may be completed using virtual care mechanisms such as telehealth.

Before admitting a patient on the basis of the first Medical Certificate the director shall:

- Verify that the **physician** who completed the Medical Certificate is fully licensed to practice medicine in British Columbia. (An educational license alone is not sufficient.) The **physician** does not have to be a psychiatrist.
- Verify that in providing their opinion, the **physician** has considered all other available sources of information about the patient such as family, relevant clinical records, police, service providers familiar with the patient's mental health status (for example, Mental Health Service Units or other mental health service agencies or community health teams).
- Examine the Certificate to ensure it is complete and the stated reasons for admission are adequate and conform to the statutory criteria in section 22 of the Act.
- Ensure that the Certificate completed by the **physician** uses clear and patient-specific language.
- Ensure that the Certificate completed by the **physician** is written in legible handwriting or printing such that all clinicians and the patient and their representatives (including family and/or near relative) can understand the reasons for the opinion of the **physician** who examined the patient.
- If necessary, seek clarification from the **physician** who signed the Medical Certificate for any of the reasons or information provided.
- Ensure that any further information provided by the physician is added to the Medical Certificate.
- Ensure that the date of the examination by the **physician** was not more than 14 days before the date of the proposed admission.

In the case of an admission for more than 48 hours based on the second Medical Certificate, directors shall ensure that:

- The second Medical Certificate was completed by a second **physician** who is also fully licensed to practice in BC.
- The second Medical Certificate was completed after an examination of the patient by a second **physician.**
- The second **physician** is not the same **physician** who completed the first Medical Certificate.
- The reasons, language and handwriting conform with the standards required for the first Certificate set out above.

- The second Medical Certificate was completed within 48 hours of the date and time the patient was initially admitted to the **designated facility**.

In the case of the first and second Medical Certificates, the director shall:

- Ensure that the patient receives a copy of their Medical Certificate(s) if requested.
- Consult with the *Freedom of Information and Protection of Privacy Act* (FOIPPA) advisor for the **designated facility** if, in the **director's** opinion, it is necessary to redact or withhold some or all of a Medical Certificate from a patient due to concerns about patient's health and safety or anyone else's health or safety.
- Document the reasons for the redaction or withholding, if some or all of the Certificate(s) is redacted or withheld.

STANDARD SEVEN – NOTIFICATION OF RIGHTS (FORMS 13, 14)

BACKGROUND

From the *Guide to the Mental Health Act* (2005):

Information staff must give patients

The **designated facility** must provide information to patients admitted involuntarily about their rights under the *Mental Health Act*. This applies to new admissions, transfers from another **designated facility** (section 35), changes from voluntary status to involuntary status, and completion of renewal certificates.

Children and youth under age 16 admitted voluntarily by a parent or guardian must also be provided with rights information.

A staff member from a **designated facility** (or its agent) must verbally inform the person and provide written notification of the following rights promptly upon admission:

- the hospital's name and location;
- the right to be informed promptly of the reasons why the person was admitted and is being kept in hospital;
- the right to contact, retain and instruct a lawyer or advocate without delay;
- the right to regular reviews of detention by a **physician** (renewal certificates);
- the right to apply for a Review Panel hearing;
- the right to have the validity of the detention determined by a court (by way of a procedure known as *habeas corpus*, where the court is asked to determine whether there is legal authority for the detention);
- the right to apply to the court for discharge; and,
- the right to a second medical opinion on the appropriateness of **treatment.**

Rights information requirements, as they apply to involuntary patients, are set out in section 34 of the Act. For patients under 16, the requirements are in section 34.1.

Rights information format

Form 13, Notification to Involuntary Patients of Rights Under the *Mental Health Act*, is used by hospital staff or a rights advisor to provide the information required by section 34 of the Act to all involuntary patients. Form 14 Notification to Patient Under Age 16, Admitted by a Parent or Guardian, of Rights Under the *Mental Health Act*, is used for voluntary patients under age 16.

STANDARDS

Operators shall:

- Provide assistance for people who may not understand the rights information because English is their second language or they have hearing difficulties.
- Ensure that a copy of the *Mental Health Act*, sections 1 to 10 of the Mental Health Regulation, and Forms 13 and 14 are posted in a conspicuous place in the designated facility in a location where they can be easily seen and accessed by patients.

Directors shall:

- As soon as possible after the relevant event under section 34(1), notify the patient of their rights by:
  - reading out loud the bolded sections of Form 13 or 14 to the patient
  - explaining the content and purpose of the form to the patient
  - encouraging the patient to ask questions
  - if the patient understands, ensuring that the patient signs the Form 13 or 14
  - explaining to the patient that in signing the form, they confirm that they understand their rights
  - placing a copy of the signed and dated form in the patient's chart, and
  - giving the patient a copy of the signed and dated form, as well as a copy of the "Know Your Rights" pamphlet.
- Ensure that rights advice is given to the patient in a manner appropriate to the patient's developmental level and ability to understand the information. The process must be patient-centered, culturally safe, and trauma informed.
- Ensure that a patient who does not speak fluent English is provided rights information in a language in which they are fluent.
- In the unusual situation where the rights notification has not been given as soon as possible after the relevant event under section 34, ensure that this omission is documented in the patient's chart along with the rationale, and ensure that rights notification is given at the next earliest opportunity.
  - If the patient declines or is unable to sign the Form 13 or 14 provide the notice to the patient and document the patient's refusal or inability to complete the form and maintain a copy on file In the case of inability, where there is some possibility that capacity to understand the rights advice might be restored, at least once every 12 hours, ensure that a physician, social worker, psychologist, registered nurse, nurse practitioner or registered psychiatric nurse assesses the patient's capability to understand the rights information and if such capacity is restored, notify the patient of the rights, as set out above.
  - .
  - Ensure that the patient is given a copy of the Form 13 or 14, signed and dated by the director (or designate)[14] and the "Know Your Rights" pamphlet.
  - Ensure that family members or representatives do not sign Form 13 or 14 for the patient.

[14] If it is necessary due to concerns for safety, the physician director may sign the Form 13 or 14 using their given name and first initial of their surname only. Physicians and directors must always include their professional designations.

- Ensure that the rights advice and completion of a new Form 13 or 14 is repeated:
  - Each time a new Form 6 (renewal certificate) is completed.
  - If the patient's status changes from voluntary to involuntary.
  - If the patient transfers to another designated facility.
  - Any time the patient or family has questions, or any member of the care team feels it is necessary to provide this information to ensure that the patient has been advised of and understood their rights.

STANDARD EIGHT – CONSENT FOR TREATMENT (FORM 5)

BACKGROUND

From the *Guide to the Mental Health Act* (2005):

> The *Mental Health Act* provides for compulsory **treatment** of all involuntary patients. The director may authorize **treatment** for patients who are mentally incapable of making a consent decision about the proposed **treatment**.
>
> Prior to **treatment** of involuntary patients, the Consent for **Treatment** (Involuntary Patient) form (Form 5) must be completed and signed. Failure to do so could lead to legal liability.

STANDARDS

Before authorizing treatment based on the Form 5, the director shall ensure that:

- The description of the **treatment** proposed by the **physician:**
  - Is of sufficient detail, and specifically that the **physician** has set out the nature of the patient's mental health diagnosis, nature of the condition, , options for **treatment, the reasons for and** the likely benefits and risks of the proposed **treatment** for the patient.
  - Is sufficiently descriptive: for example, it includes details of medication class and behavioural therapy type (it is not necessary to list individual medications).
  - Constitutes psychiatric **treatment** only and does not purport to authorize **treatment** for which consent of the patient, or their substitute decision maker, is required under the *Health Care (Consent) and Care Facility (Admission) Act*.
  - Does not purport to authorize **treatment** for a patient who has not been involuntarily admitted in accordance with the *Mental Health Act.*
  - Describes the specific patient's proposed course of **treatment** in plain language, specific to the actual **treatment** required by the particular patient, and is set out in legible printing or handwriting.
  - That the **physician** who has completed the form has not use rubber stamps, generic or "boilerplate" language which is not specific to the circumstances of the patient.
- The Form 5 is completed:
  - As soon as possible upon the involuntary admission of the patient and not more than 24 hours after the **director** has involuntary admitted the patient to the **designated facility**.
  - Each time there is a significant change in **treatment**, which was not contemplated in a prior Form 5 and specifically where there is a change in the patient's diagnosis which requires a different **treatment** plan.

STANDARD NINE – NOMINATION OF NEAR RELATIVE (FORM 15)

BACKGROUND

From the *Guide to the Mental Health Act* (2005):

> Section 34.2 of the Act requires that, immediately after the involuntary admission of a patient under section 22 or the voluntary admission of a child or youth under age 16 (section 20 (1) (a) (ii)), the **director** [must] send a written notice (Form 16, Notification to **Near Relative** (Admission of Involuntary Patient or Patient Under Age 16)) to a **near relative**.
>
> The Act now defines **near relative** as a "grandfather, grandmother, father, mother, son, daughter, husband, wife, brother, sister, half brother or half sister, friend, caregiver or companion designated by the patient and includes the legal guardian of a minor and a committee having custody of the person of a patient under the *Patients Property Act*." While not mentioned in the Act, common law spouse and same sex partner are included as **near relatives**.
>
> The notification may be sent to any **near relative**. Form 15, Nomination of Near Relative, must be used for the patient to nominate **the near relative** they wish to be notified.

STANDARDS

The director shall:

- Immediately after the involuntary admission of a patient or the voluntary admission of a child or youth, complete Form 15 (Nomination of **Near Relative**) by recording the name and contact information of the **near relative** nominated by the patient.
- Select the **near relative** if the patient, child or youth declines to nominate a near relative or their health status (e.g., severe psychosis, agitation, or other conditions) prevents them from being able to do so, and in such case, make a note on the Form 15 and in the patient's chart that the patient declined or was unable to nominate a near relative.
- Permit a patient to change their choice of **near relative** at any time. If the patient so requests, a new Form 15 shall be completed after which all notices shall be sent to the new **near relative**.
- In addition to the near relative selected by the patient, the **director** may, if the **director** considers it to be in the best interests of the patient or the safety of others, send the notice to any other **near relative**. See Standard 12 on disclosure of information to other third parties]
- Notify any known representative under a Representation Agreement or attorney under an Enduring Power of Attorney upon the patients' admission.

STANDARD TEN – NOTIFICATION OF NEAR RELATIVE (FORM 16)

BACKGROUND

From the Guide to the Mental Health Act (2005):

> Section 34.2 of the Act requires that, immediately after the involuntary admission of a patient under section 22 or the voluntary admission of a child or youth under age 16 (section 20 (1) (a) (ii)), the **director** send a written notice (Form 16, Notification to **Near Relative** (Admission of Involuntary Patient or Patient Under Age 16)) to a **near relative**.
>
> Form 16 explains the patient's right to Renewal Certificate examinations, to a second medical opinion on the appropriateness of the patient's **treatment**, to apply for a Review Panel hearing and to apply to the court under section 33 (2). These applications may be made by the patient, a relative or any other person on behalf of the patient.

In this section "committee" means:

- A private person appointed as committee for the patient under the *Patients Property Act* or
- The Public Guardian and Trustee (PGT) if (a) appointed as statutory property guardian (SPG) for the patient under the *Adult Guardianship Act,* or (b) because the PGT was appointed by the court as a **committee** under the *Patients Property Act.*

STANDARDS

The director shall:

- Immediately after Form 15 is completed, complete the Form 16 (Notification to **near relative**: Admission of Involuntary Patient or Patient under Age 16) and send it to the **near relative** nominated by the patient.
- If practical (i.e., when the **near relative** is present in the **designated facility**) ensure that the Form 16 is delivered by hand to the **near relative**.
- If not practical to hand deliver the Form 16 to the **near relative**, ensure that the Form 16 is delivered to the **near relative** by registered mail using Canada Post, which includes confirmation of delivery.
- Keep a copy of the Form 16 in the patient's file and make a notation in the file describing the method of delivery to the **near relative**.
- If the Form 16 is delivered by registered mail via Canada Post and no confirmation of receipt is received within seven days, make a notation in the patient's file that that no confirmation of receipt was received and request the patient to nominate another **near relative** by completing a second Form 15.
- Repeat the steps above to notify the second **near relative** nominated by the patient.

In the case of all involuntary admissions of patients, the director shall take the following steps to determine if a person has been appointed as a committee for the patient:

- Ask the patient, and, if accompanied by a friend or relative, the friend or relative, whether the patient has a committee, and whether it is private or the PGT.
- If the answer is in the affirmative that there is a committee and it is the PGT, then notify the PGT of the patient's admission by sending them the Form 16.
- If the answer is in the affirmative that there is a private committee, then notify the private committee of the patient's admission by sending them the Form 16.
- Registered mail shall always be used when sending the Form 16 to the PGT or private committee.

STANDARD 11 – ACCESSING THE MENTAL HEALTH REVIEW BOARD (FORMS 7, 8)[15]

BACKGROUND

Health authorities should become familiar with and follow the Practice Directions established by the Mental Health Review Board.

The purpose of the Review Board is to decide, after a hearing, whether a patient should be discharged from involuntary admission based on evidence considered at the hearing. If the Review Board determines that the patient does not meet the criteria for involuntary admission, the **director** must discharge the patient from involuntary admission although the patient may remain admitted on a voluntary basis.

STANDARDS

- If a person on the patient's behalf applies for a Review Panel Hearing, the **director** shall send notice of the request to the **near relative** by completing the Form 18 and hand-delivering, or when hand-delivery is not possible, sending the form to the **near relative.**

[15] These standards and reference BC's Mental Health Review Board (MHRB) and mental health review panels. The MHRB is distinct from the BC Review Board, which is an independent tribunal established under the Criminal Code of Canada. The respective review boards provide distinct functions governed by distinct legislation. When individuals are detained under the Criminal Code and also admitted for involuntary **treatment** under the *Mental Health Act* it is important to ensure that these standards are applied only to their engagement with the MHRB with respect to their involuntary status under the Act.

STANDARD 12 – DISCLOSURE OF PERSONAL INFORMATION TO THIRD PARTIES

BACKGROUND

In this standard the phrase "third parties" refers to family members, friends and relatives of the patient, as well as guardians, representatives and committees.

The *Mental Health Act* authorizes the disclosure of some personal information to third parties. For example:

- Pursuant to section 34.2, the **director** must notify the **near relative** nominated by the patient of the circumstances described in section 34.2.
- If the **director** has no information about the identity of the patient's **near relative**, the director may send the notice to the Public Guardian and Trustee.

However, there may be circumstances when it is necessary to disclose patient information to third parties in circumstances which are not expressly contemplated by the *Mental Health Act*. For example:

- if the patient is incapable of selecting a **near relative** for the purpose required by section 34.2 and it is necessary for the **director** to select the **near relative** and to send the notice to the person selected by the **director**;
- if the **director** considers it to be in the best interests of the patient, or the safety of others, it may be necessary for the **director** to send the notice referred to in section 34.2 to another **near relative** in addition to the person nominated by the patient;
- it may also be necessary to disclose information to third parties for the purpose of continuity of care of the patient;
- or it may be necessary to disclose information to third parties to protect the health and safety of the patient or others.

Most operators of designated facilities are governed by the *Freedom of Information and Protection of Privacy Act* (FOIPPA). FOIPPA permits the disclosure of personal information collected by a public body with the consent of the individual, and also permits the disclosure of personal information in limited circumstances where the individual has not consented to the disclosure or where the individual has refused disclosure of their personal information.

Disclosure of personal information without the consent of the patient or despite the refusal of the patient can place an individual health care provider in a difficult situation as they will be concerned not only with the patient's general wellbeing and the concerns of third parties, but also preserving the trust

of the patient. This concern can be partially mitigated by ensuring that only necessary information is released to third parties so that the invasion of the patient's privacy is minimized.

However, there will be circumstances in which it may be necessary to release the personal information of the patient without the consent of the patient or despite the refusal of the patient. Such situations might include a situation where:

- A child is in the care of a **director** (an employee of the Ministry of Child and Family Development (MCFD)) under the *Child Family and Community Services Act*, and is admitted under the *Mental Health Act* (voluntarily or involuntarily). In this case it may be necessary to disclose the fact of the admission to the **director** since children in care are generally more vulnerable and will require more and different services from the director of MCFD as a result of the illness giving rise to the admission.
- A child is admitted under the *Mental Health Act* (voluntarily or involuntarily) and the child is not accompanied by their parent and does not nominate their parent as the **near relative**.
- A patient is being released from the **designated facility** into the care of a family member and it is necessary that the family member have relevant information about the medications prescribed to the patient. Or,
- A family member has indicated to the clinicians that they are fearful of their relative who was admitted under the *Mental Health Act*, because the patient has threatened them in the past.

In these circumstances, the basis upon which personal information may be disclosed to third parties pursuant to FOIPPA includes:

- for a purpose consistent with the purposes for which the personal information was collected [S 33.2(a)];
- if compelling circumstances exist that affect anyone's health or safety [S 33.1(m)];
- so that the next of kin or a friend of an injured, ill or deceased person may be contacted [S 33.1(n)]; and
- for the purpose of reducing the risk that an individual will be a victim of domestic violence, if domestic violence is likely to occur [S. 33.1(1)(m.1)].

Each of the above situations must be considered on their merits, taking into account all of the relevant clinical and social factors of the patient and the third party.

In some situations, the decision whether to disclose personal information is a decision which must be made by the "head" of the public body. Schedule 1 of FOIPPA defines the phrase "head" for this purpose. This discretion can be delegated to another person within the public body.

The Office of the Information and Privacy Commissioner (OIPC) recently issued a Guidance Document, *Disclosure of Personal Information of Individuals in Crisis*. The OIPC Guidance Document recommends that each public body delegate the authority of the "head" of the public body to make disclosure decisions "to a person or the available person in a designated position who is always readily available

and trained to make that determination to ensure there is always someone available who can make these decisions on behalf of the public body."[16]

The OIPC Guidance Document also provides that the individuals to whom the decision making authority has been delegated should be trained on how to meet the disclosure provisions of FOIPPA: "The public bodies should also train their staff to know that the individuals in this position have the delegated authority from the head of the public body to exercise discretion to disclose personal information in certain circumstances."[17]

Proper documentation should accompany the decision to disclose the information including the name of the person making the disclosure decision, the information disclosed, and to whom the information was disclosed. This information must be recorded in the clinical file (the patient's chart).

STANDARDS

Operators of designated facilities shall:

- Delegate, in writing, the authority of the head of the public body to make decisions respecting disclosure of personal information of patients to third parties to the **director** and to all persons who may perform the duties of the **director** under the *Mental Health Act.*
- Ensure that every person to whom the authority to make disclosure decisions has been delegated receives training in the disclosure of personal information of patients to third parties pursuant to the *Mental Health Act* and FOIPPA.

Directors shall:

- Ensure there is always a person who is authorized and readily available to clinicians to make disclosure decisions.
- Ensure that all staff working in all designated mental health facilities know of and know how to contact the person(s) who have the delegated authority to make disclosure decisions.

[16] Office of the Information and Privacy Commissioner (OIPC) for British Columbia (2019), *Guidance Document: Disclosure of Personal Information of Individuals in Crisis*, p. 4. Retrieved from https://www.oipc.bc.ca/guidance-documents/2336.
[17] OIPC for BC (2019), p. 4.

GLOSSARY

The following terms used in this document have the same meaning as defined in section 1 of the *Mental Health Act:*

"designated facility" means a Provincial mental health facility, psychiatric unit or observation unit. In essence, this phrase refers to specific hospitals or other facilities where a person may be admitted under the authority of the Mental Health Act**.**

"director" means a person appointed under the regulations to be in charge of a designated facility and includes a person authorized by a director to exercise a power or carry out a duty conferred or imposed on the director under this Act or the *Patients Property Act*. See Standard 1 for an explanation the appointment of the director and who can act on behalf of the director.

"near relative" means a grandparent, parent, child, spouse, sibling, half sibling, friend, caregiver or companion designated by a patient and includes the legal guardian of a minor and a representative under an agreement made under the *Representation Agreement Act* and a committee having custody of the person of a patient under the *Patients Property Act*;

"patient" means a person who, under this Act, (a) is receiving care, supervision, treatment, maintenance or rehabilitation, or (b) is received, detained or taken charge of as a person with a mental disorder or as apparently a person with a mental disorder.

"physician" means a medical practitioner. Section 29 of the *Interpretation Act*, R.S.B.C. 1996 c. 238 defines "medical practitioner" to mean a registrant of the College of Physicians and Surgeons of British Columbia entitled under the *Health Professions Act* to practice medicine and to use the title "medical practitioner."

"treatment" means safe and effective psychiatric treatment and includes any procedure necessarily related to the provision of psychiatric treatment.

The following terms used in this document have the same meaning as set out in the *Guide to the Mental Health Act, 2005, Appendix 18*:

"Admission" refers to admission to a designated facility as a voluntary or involuntary patient under the

Mental Health Act, or as a voluntary patient under the *Hospital Act*. It should be noted that a patient may be in hospital as a voluntary patient at the time that he/she is admitted as an involuntary patient.

"Discharge" may refer to termination of status as an involuntary patient or termination of stay in a designated facility. For example, patients can be discharged from involuntary status without being discharged from the designated facility, if their status is changed to voluntary.

APPENDIX A

CORE PROVINCIAL AUDIT: MINIMUM REPORTING REQUIREMENTS

TRAINING

Since June 1, 2019, designated mental health facilities Directors, **physician**s and staff exercising authority under the *MHA* have completed provincially approved training:

Item		**Complete**		
		Total # expected to be trained	**Actual # trained**	**% trained**
MHA online module (asynchronous)	***Directors****/Designates*			
	Physicians			
	Staff			
MHA face-to-face session (synchronous – may be delivered virtually)	***Directors****/ Designates*			
	Physicians			
	Staff			
Cultural safety training (San'yas or similar)[18]	***Directors****/ Designates*			
	Physicians			
	Staff			
New **Directors, physicians,** staff have completed an online MHA module within one month of hire	***Directors****/ Designates*			
	Physicians			
	Staff			

FORMS

All noted elements of the form must be complete as described for the form to be assessed as complete. ***Any unacceptable or missing content renders the entire form incomplete.***

- Unless otherwise specified, **any format for times, dates, telephone numbers, designated facility names, individual names and positions/titles** is acceptable for the purposes of this completion audit
- For all required **signatures**: any form of signature is acceptable; blank is unacceptable
- **Designated facility address:** full street address; *do not* require province, country, postal code

[18] Note that cultural safety training is strongly encouraged as part of the provincially approved training, and Operators are encouraged to develop and offer face-to-face training sessions, but per the standards and guidelines neither is required.

- **Near relative:** First and last name, 10-digit phone number and full street address including province and postal code
- **Patient name** on forms should always be consistent with what is present in the most recent Form 4

Note that **admission** begins when the Director of a designated facility admits a patient to the designated facility on the basis of the Form 4 (Medical Certificate).

All patients admitted involuntarily are required to have at least one completed Form 4, as well as at least one completed Form 5, 13, 15 and 16. Only patients admitted involuntarily for more than 48 hours will require a second Form 4.

Form 4

- The form is considered complete whether or not the box regarding section 28 has been checked.
- For the purpose of assessing completion, **reasons for opinion** may be as minimal as 'yes, the person meets the criteria'.
- For assessing *quality*, **reasons for opinion** must document explicitly how the patient meets *all four* of the following admission criteria:
    - Is suffering from disorder of the mind that requires treatment and seriously impairs the person's ability to react appropriately to their environment or to associate with others,
    - Requires psychiatric treatment in or through a designated facility,
    - Requires care, supervision and control in or through a designated facility to prevent their substantial mental or physical deterioration or for their own protection or the protection of others, *and*
    - Is not suitable as a voluntary patient.
- All patients admitted involuntarily are required to have at least one completed Form 4. Only patients admitted involuntarily for more than 48 hours will require a second Form 4.
- **Patients admitted for 48 hours or more should have TWO completed Form 4s in their chart. For these patients, please audit each Form 4 using the appropriate checklist below**.

Completion Indicators – 1st Form 4		
Item	**Complete**	
	Yes	**No**
The following shall be present on all Form 4s:		
Examining physician's name, signature, address (name of facility (may be abbreviated) and/or full street address), telephone number and date of signing		
Patient's name and date of examination		
Reasons for opinion box is filled in		
Summary – 1st Form 4		
Present (form present/attempted but not complete)		
Complete		
Patient required only the 1st Form 4 (i.e., discharged from *Mental Health Act* in less than 48 hours)		

Quality Indicators – 1st Form 4	**Yes**	**No**	**Partial**

Completed on the day of the patient's involuntary admission			
Completed in legible handwriting or printing according to the provincial standards			
Chart includes the Director or delegate's name and signature approving involuntary admission for up to 48 hours from the date/time of admission			
Diagnosis or general syndrome (i.e., a recognized psychiatric syndrome when the specific diagnosis is not clear, such as psychosis or depression)			
Description of current symptoms or behaviours			
Impact of symptoms or behaviours			
Nature and description of the risk			
Reasons for involuntary admission and treatment			
Reasons why the person can't be treated voluntarily			
Quality Indicators – 1st Form 4		**Yes**	**No**
Completed on the day of the patient's involuntary admission			
Completed in legible handwriting or printing according to the provincial standards			
Chart includes the Director or delegate's name and signature approving involuntary admission for up to 48 hours from the date/time of admission			

Completion Indicators – 2nd Form 4		
Item	**Complete**	
	Yes	**No**
The following shall be present on all Form 4s:		
Examining physician's name, signature, address (name of facility and/or full street address), telephone number and date of signing		
Patient's name and date of examination		
Reasons for opinion box is filled in		
Summary – 2nd Form 4		
Present (form present/attempted but not complete)		
Complete		

Quality Indicators – 2nd Form 4	**Yes**	**No**	**Partial**
Completed for an involuntary admission lasting longer than 48 hours			
Completed in legible handwriting or printing according to the provincial standards			
Chart includes the Director or delegate's name and signature approving involuntary admission for up to one month from the date when the second Form 4 has been completed			
Chart confirms that the second examination and the second Form 4 were completed within 48 hours of admission to the designated facility.			
Diagnosis or general syndrome (i.e., a recognized psychiatric syndrome when the specific diagnosis is not clear, such as psychosis or depression)			
Description of current symptoms or behaviours			
Impact of symptoms or behaviours			
Nature and description of the risk			

Reasons for involuntary admission and treatment			
Reasons why the person can't be treated voluntarily			

Form 5

- Only one of section A or section B must be completed.
- It is acceptable to have some of section A complete as well as all of section B; if this is the case, only audit section B.
- Extraneous content in section A does NOT invalidate the form or suggest it is incomplete.

Completion Indicators			
Item	**Complete**		
	Yes	**No**	**N/A**
Description of treatment/course of treatment:			
Handwriting/printing is legible.			
Name and title of person who explained the form to the patient: minimum first initial and last name, and job/employment role			
Description box is filled in and is NOT pre-printed or stamped			
Section A (if applicable – signed by patient)			
Patient's name and signature			
Date and time the patient signed			
Witness' name and signature			
Treating physician's signature			
Section B (if applicable – not signed by patient)			
Top section			
Director/Delegate's name			
Patient's name			
Name of designated facility			
Bottom section			
Director or delegate's name (must be different from name of physician), signature, position/title, and date and time signed			
Treating physician's signature			
Summary – Form 5			
Present (form present/attempted but not complete)			
Complete			

Quality Indicators	**Yes**	**No**	**Partial**	**N/A**
Completed within 24 hours following involuntary admission or change from voluntary to involuntary status				
Completed in legible handwriting or printing according to the provincial standards				
Authorizes psychiatric treatment only and does not refer to non-psychiatric treatment				
Completed using a "rubber stamp," or generic or "boilerplate" language that is not specific to the circumstances of the patient *(note that the desired answer to this is NO)*				

Chart includes the Director or delegate's name and signature approving the proposed treatment as outlined in form 5				
A new Form 5 was completed to show and obtain consent for any significant change to treatment				
The Director/Delegate authorizing treatment was not also the treating physician				
Description includes:				
Medications listed by class or indication				
Reasons for admission to hospital				
General description of planned investigations, relevant to that patient				
The following items are mandatory in the description if currently applicable:				
Clozapine				
ECT or neurostimulation				
Seclusion or restraint				
Description of specific psychotherapeutic modality beyond standard treatment. A psychotherapeutic modality should be specifically listed if it is unique to the patient or program, and is more than the usual supportive psychotherapy provided during standard care, such as: a) Contingency management for addictions; b) Cognitive therapy for schizophrenia; c) A specific modality of group psychotherapy.				

Form 13/14

A patient may have more than one Form 13/14 in their chart depending on the circumstances of their admission (i.e., if they required a renewal or transfer). Audits should note the presence/absence of one completed Form 13/14 in the patient's chart.

Completion Indicators		
Item	**Complete**	
	Yes	**No**
The following shall be present on all Form 13/14s:		
Name and location of facility		
Patient's name		
Name of person who provided information (first name and last initial are acceptable)		
Complete the following:		
Patient admitted less than 24 hours.		
Summary – Form 13/14		
Present (form present/attempted but not complete)		
Complete		

Quality Indicators	**Yes**	**No**
Completed within 24 hours of completion of the first Form 4 and admission to the designated facility		

Form 15

A patient may have more than one Form 15 in their chart if they changed their choice of near relative or had to nominate a different near relative if the first was inaccessible. The audit should note the presence of at least one complete Form 15 in the patient's chart that nominates the same near relative named in a Form 16. If there are multiple Form 15s, *audit the most recent one.*

Completion Indicators		
Item	**Complete**	
	Yes	**No**
The following shall be present on all Form 15s:		
Patient's name		
Name of facility		
Name, phone number and address of the near relative		
Check in the corresponding box indicating the relationship of the near relative		
Appropriate boxes checked		
Staff signature (under "For office use only")		
Complete the following:		
Patient admitted less than 24 hours		
There was more than one Form 15 in the patient's chart		
The Form 15 audited nominates the same near relative named in the patient's Form 16		
Summary – Form 15		
Present (form present/attempted but not complete)		
Complete		

Quality Indicators	**Yes**	**No**
Completed within 24 hours of involuntary admission to the designated facility		

Form 16

A patient may have more than one Form 16 in their chart if they changed their choice of near relative or had to nominate a different near relative if the first was inaccessible (see Form 15). The audit should note the presence of one complete Form 16 in the patient's chart that notifies the *same near relative named in the Form 15*.

Completion Indicators		
Item	**Complete**	
	Yes	**No**
The following shall be present on all Form 16s:		
Near relative's name, address and phone number		
Patient's name and date of admission		
Check in the corresponding box indicating whether patient is involuntary and/or under age 16		
Name and address of the facility		
Director/Delegate's name, signature and date signed		
Complete the following:		

Patient admitted less than 24 hours		
There was more than one Form 16 in the patient's chart		
The Form 16 audited notifies the same near relative nominated in the patient's Form 15		
Summary – Form 16		
Present (form present/attempted but not complete)		
Complete		

Quality Indicators	**Yes**	**No**
Completed within 24 hours of involuntary admission to the designated facility or change to involuntary status		