PRINCE EDWARD ISLAND
ÎLE-DU-PRINCE-ÉDOUARD

MENTAL HEALTH ACT
GENERAL REGULATIONS

PLEASE NOTE

This document, prepared by the ***Legislative Counsel Office***, is an office consolidation of this regulation, current to February 1, 2024. 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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GENERAL REGULATIONS

Table of Contents

Section Page

1. Psychiatric facilities 5
2. Forms 5

SCHEDULE **6**

FORM 1 **6**

ORDER FOR INVOLUNTARY PSYCHIATRIC ASSESSMENT 6

FORM 2 **7**

ORDER FOR INVOLUNTARY PSYCHIATRIC ASSESSMENT 7

FORM 3 **8**

CERTIFICATE OF INVOLUNTARY ADMISSION 8

FORM 4 **9**

CERTIFICATE OF RENEWAL OF INVOLUNTARY ADMISSION 9

FORM 5 **10**

CERTIFICATE OF LEAVE 10

FORM 6 10

CERTIFICATE OF CANCELLATION OF LEAVE 10

FORM 7 **11**

CERTIFICATE OF INCAPACITY 11

FORM 8 **12**

COMMUNITY TREATMENT ORDER 12

FORM 9 **13**

RENEWAL OF COMMUNITY TREATMENT ORDER 13

FORM 10 **14**

ORDER FOR PSYCHIATRIC ASSESSMENT 14

FORM 11 **15**

NOTICE OF REVOCATION OF COMMUNITY TREATMENT ORDER 15

MENTAL HEALTH ACT
CHAPTER M-6.2

GENERAL REGULATIONS

Pursuant to section 37 of the *Mental Health Act* R.S.P.E.I. 1988, Cap. M-6.2, Council made the following regulations:

1. Psychiatric facilities

For the purpose of clause 1(t) of the Act, the following facilities are designated for the assessment, care and treatment of persons who have or may have a mental disorder:

(a) Hillsborough Hospital;

(b) Prince County Hospital;

(c) Queen Elizabeth Hospital. *(EC35/24)*

2. Forms

The forms prescribed for the purposes of the Act are set out in the Schedule to these regulations and form part of these regulations. *(EC35/24)*

SCHEDULE

FORM 1

ORDER FOR INVOLUNTARY PSYCHIATRIC ASSESSMENT

(Section 8, *Mental Health Act*)

I, _____________________ (name and designation of medical practitioner or nurse practitioner), personally examined __________________ (name or description of person) of _________________ (person's address) on ________ __ (mm/dd/yy) at ___________(time) at ___________________ (name of health facility).

It is my opinion that
(a) the person has a mental disorder; and
(b) as a result of the mental disorder, the person (check, as appropriate)
___ has caused or is likely to cause harm to the person or to others, or
___ is likely to suffer substantial physical or mental deterioration or impairment.

I confirm that the person refuses or is unable to consent to a psychiatric assessment.

Supporting information: (e.g. details of examination, observations, basis for opinion):
____

____

Based on the foregoing, I, by this order, refer the person to a psychiatrist for an involuntary psychiatric assessment.

This order is sufficient authority
(a) for a peace officer to apprehend the person who is named or described in the order and take the person to a psychiatric facility; and
(b) for a psychiatrist to
(i) detain, restrain and observe the person in a psychiatric facility for not more than 72 hours, and
(ii) conduct an involuntary psychiatric assessment of the person.

Dated ________ (mm/dd/yy) at ________ (time) ____________________ (signature of practitioner)

(EC35/24)

FORM 2

ORDER FOR INVOLUNTARY PSYCHIATRIC ASSESSMENT

(Section 9, *Mental Health Act*)

I, Dr. _________________(name of attending psychiatrist), am responsible for the care and treatment of ___________________(name or description of patient) of______________ (patient's address), who is currently a voluntary patient at ___________________ (name of psychiatric facility), from which the patient has requested to be discharged.

I have reasonable grounds to believe that
(a) the person has a mental disorder; and
(b) as a result of the mental disorder, the person (check, as appropriate)
___ has caused or is likely to cause harm to the person or to others; or
___ is likely to suffer substantial physical or mental deterioration or impairment.

I confirm that the patient refuses or is unable to consent to a psychiatric assessment.

Supporting grounds (e.g. mental disorder, details of voluntary care and treatment, observations):
____

____

Based on the foregoing, I order that the patient undergo an involuntary psychiatric assessment.

This order is sufficient authority for the attending psychiatrist to
(a) detain, restrain and observe the patient in a psychiatric facility for not more than 72 hours; and
(b) conduct an involuntary psychiatric assessment of the patient.

Dated ______ (mm/dd/yy) at _______ (time) ________________ (signature of attending psychiatrist)

(EC35/24)

FORM 3

CERTIFICATE OF INVOLUNTARY ADMISSION

(Section 10, *Mental Health Act*)

I, Dr.__________________ (name of psychiatrist), have personally conducted a psychiatric assessment of _____________________ (name or description of person) of ________________ (person's address), within the previous 72 hours at ________________ (name of psychiatric facility) from _____(time) on ___________ (mm/dd/yy) to _________ (time) on ________ (mm/dd/yy).

I have made careful inquiry into all the facts necessary as to the nature of the person's mental condition and it is my opinion that

(a) the person has a mental disorder; and
(b) as a result of the mental disorder, the person (check, as appropriate)
___ has caused or is likely to cause harm to the person or to others; or
___ is likely to suffer substantial physical or mental deterioration or impairment; and
(c) the person requires care and treatment in a psychiatric facility.

I confirm that the person refuses or is unable to consent to admission to a psychiatric facility.

Description of the facts and personal observations upon which I have formed my opinion:

____

Description of information received from other sources (identify sources):

____

Based on the foregoing, I admit this person to a psychiatric facility as an involuntary patient under section 10 of the *Mental Health Act*.

This certificate expires 30 days from the date it is issued unless sooner cancelled by the attending psychiatrist.

Date issued: ____________ (mm/dd/yy) ____________________________ (signature of psychiatrist)

(EC35/24)

FORM 4

CERTIFICATE OF RENEWAL OF INVOLUNTARY ADMISSION

(Section 11, *Mental Health Act*)

I, Dr. _________________ (name of attending psychiatrist), have personally conducted a psychiatric assessment of __________________ (name or description of patient) of ______________ (person's address), within the previous 72 hours at _________________ (name of psychiatric facility) from ________ (time) on ________ (mm/dd/yy) to _______ (time) on ________ (mm/dd/yy).

I have made careful inquiry into all the facts necessary as to the nature of the patient's mental condition and it is my opinion that

(a) the person has a mental disorder; and
(b) as a result of the mental disorder, the person (check, as appropriate)
___ has caused or is likely to cause harm to the person or to others; or
___ is likely to suffer substantial physical or mental deterioration or impairment; and
(c) the person requires care and treatment in a psychiatric facility.

I confirm that the patient refuses or is unable to consent to admission to a psychiatric facility.

Description of the facts and personal observations upon which I have formed my opinion:
____

Description of information received from other sources (identify sources):
____

Based on the foregoing, I hereby continue the involuntary admission of the patient in a psychiatric facility under section 11 of the *Mental Health Act*.

This certificate is the patient's
___ first certificate of renewal and expires 30 days from the date it is issued, unless sooner cancelled by the attending psychiatrist;
___ second or third certificate of renewal and expires 90 days from the date it is issued, unless sooner cancelled by the attending psychiatrist; or
___ fourth or subsequent certificate of renewal and expires 12 months from the date it is issued, unless sooner cancelled by the attending psychiatrist.
Date issued: _____________ (mm/dd/yy) ___________________ (signature of attending psychiatrist)

(EC35/24)

FORM 5

CERTIFICATE OF LEAVE

(Section 15, *Mental Health Act*)

I, Dr. ______________ (name of attending psychiatrist), hereby authorize ______________ (name or description of patient) of _______________ (patient's address), who is an involuntary patient at _______________ (name of psychiatric facility), to be absent from the psychiatric facility from ________ (time) on ___________ (mm/dd/yy) to ________ (time) on ____________ (mm/dd/yy).

The following conditions apply in respect of this authorization:
____
____
____

Date issued _________ (mm/dd/yy) _____________________ (signature of attending psychiatrist)

(EC35/24)

FORM 6

CERTIFICATE OF CANCELLATION OF LEAVE

(Section 15, *Mental Health Act*)

I, Dr. ___________________ (name of attending psychiatrist), hereby cancel the Certificate of Leave issued on ______ (mm/dd/yy) in respect of __________________ (name or description of patient) of ____________ (patient's address), an involuntary patient at __________ (name of psychiatric facility).

It is my opinion that (check, as applicable)
____ as a result of the mental disorder, the patient has caused or is likely to cause harm to the patient or others while on leave; or
____ the patient has failed to comply with the terms and conditions of the Certificate of Leave.

Supporting information:
____

____

This certificate is sufficient authority for a peace officer to apprehend the involuntary patient named or described in the certificate and take the involuntary patient back to the psychiatric facility.

Date issued ________ (mm/dd/yy) ________________________ (signature of attending psychiatrist)

(EC35/24)

FORM 7

CERTIFICATE OF INCAPACITY

(Section 17, *Mental Health Act*)

I, Dr. _________________ (name of attending psychiatrist), am of the opinion that ______________ (name or description of patient) of _________________ (patient's address) is not capable in accordance with Part II of the *Consent to Treatment and Health Care Directives Act* R.S.P.E.I. 1988, Cap.C-17.2, in respect of treatment, as outlined below.

I performed a capacity assessment of the patient on ________ (mm/dd/yy) of the following nature:

____

It is my opinion that the scope of the patient's incapacity is as follows:

____

The reasons for my opinion are as follows:

____

Date issued ________ (mm/dd/yy) ______________________ (signature of attending psychiatrist)

(EC35/24)

FORM 8

COMMUNITY TREATMENT ORDER

(Section 18, *Mental Health Act*)

I, Dr. _________________ (name of psychiatrist), hereby issue this community treatment order for ____________________ (name or description of person) of ____________________ (person's address).

I confirm the following conditions are met:

(a) within the previous two years, the person has been (check, as applicable)
  ___ admitted as an involuntary patient in a psychiatric facility on two or more separate occasions, for a total of at least 30 days, or
  ___ the subject of a prior community treatment order;

(b) I have conducted a psychiatric assessment of the person within the previous 72 hours and it is my opinion that
  (i) the person has a mental disorder,
  (ii) as a result of the mental disorder, the person (check, as applicable)
    ___ has caused or is likely to cause harm to the person or others, or
    ___ is likely to suffer substantial physical or mental deterioration or impairment;
  (iii) the person requires community treatment, and
  (iv) the person is not capable of giving or refusing consent to community treatment, but is able to comply with a community treatment order;

(c) the community treatment the person requires exists in the community and is available and will be provided to the person;

(d) the person's substitute decision-maker has consented on behalf of the person to the community treatment plan.

Supporting facts:

____

The community treatment plan for the person is attached or as follows:

____

The person who is subject to this community treatment order shall comply with this order.

I am responsible for the supervision and management of this order but may appoint another psychiatrist to be responsible, where necessary.

This order expires on __________ (mm/dd/yy).

Date issued ________ (mm/dd/yy) ________________________________ (signature of psychiatrist)

(EC35/24)

FORM 9

RENEWAL OF COMMUNITY TREATMENT ORDER

(Section 20, *Mental Health Act*)

I, Dr. ______________________ (name of responsible psychiatrist), hereby renew the community treatment order issued on _________ (mm/dd/yy) and expiring on ________ (mm/dd/yy) for ____________________ (name or description of person) of ____________________ (person's address).

I confirm the following conditions are met:

(a) I have conducted a psychiatric assessment of the person within the previous 72 hours and it is my opinion that

(i) the person has a mental disorder,

(ii) as a result of the mental disorder, the person (check, as applicable)

___ has caused or is likely to cause harm to the person or others, or

___ is likely to suffer substantial physical or mental deterioration or impairment;

(iii) the person requires community treatment, and

(iv) the person is not capable of giving or refusing consent to community treatment, but is able to comply with a community treatment order;

(b) the community treatment the person requires exists in the community and is available and will be provided to the person;

(c) the person's substitute decision-maker has consented on behalf of the person to the community treatment plan.

Supporting facts:
____

The community treatment plan for the person is attached or as follows:
____

The person who is subject to this community treatment order shall comply with this order.

I am responsible for the supervision and management of this order but may appoint another psychiatrist to be responsible, where necessary.

This order expires on __________ (mm/dd/yy).
Date issued ________ (mm/dd/yy) ________________________________ (signature of psychiatrist)

(EC35/24)

FORM 10

ORDER FOR PSYCHIATRIC ASSESSMENT

(Section 22, *Mental Health Act*)

I, Dr. _________________ (name of psychiatrist), am the responsible psychiatrist for the community treatment order issued on ___________ (mm/dd/yy) for ____________________ (name or description of person) of ______________________ (address of person).

I hereby order an involuntary psychiatric assessment of the person on the basis that

(a) either (check, as applicable)

____ despite reasonable efforts to assist the person, the person does not comply with the community treatment order, or

____ the revocation of the community treatment order is required under section 23 of the Act;

(b) I have reasonable grounds to believe that

(i) the person has a mental disorder, and

(ii) as a result of the mental disorder, the person (check, as applicable)

____ has caused or is likely to cause harm to the person or others, or

____ is likely to suffer substantial physical or mental deterioration or impairment; and

(c) the person refuses or is unable to consent to a psychiatric assessment.

Supporting information and grounds:

____

____

This order is valid for 30 days and is sufficient authority for

(a) a peace officer to apprehend the person who is named in the order and take the person to a psychiatric facility; and

(b) a psychiatrist to

(i) detain, restrain and observe the person in a psychiatric facility for not more than 72 hours, and

(ii) conduct an involuntary psychiatric assessment of the person.

Dated ___________ (mm/dd/yy) ________________________ (signature of responsible psychiatrist)

(EC35/24)

FORM 11

NOTICE OF REVOCATION OF COMMUNITY TREATMENT ORDER

(Section 23, *Mental Health Act*)

I, Dr. _____________ (name of psychiatrist), am the responsible psychiatrist for the community treatment order issued on __________ (mm/dd/yy) for ________________ (name or description of person) of ______________ (address of person).

The community treatment order is hereby revoked on the following basis (check, as appropriate):

____ I am of the opinion that one or more of the following criteria are no longer met: (circle)

(i) the person has a mental disorder,

(ii) as a result of the mental disorder, the person

(A) has caused or is likely to cause harm to the person or others, or

(B) is likely to suffer substantial physical or mental deterioration or impairment;

(iii) the person requires community treatment, and

(iv) the person is not capable of giving or refusing consent to community treatment, but is able to comply with a community treatment order;

____ the community treatment the person requires no longer exists in the community or is no longer available or provided to the person; or

____ the person's substitute decision-maker no longer consents to the community treatment plan.

Supporting information:

____

____

(EC35/24)