Supervised Community Care Plan - Application and Care Plan
Mental Health Act, Part II.I

New Nouveau Brunswick

PART I

Supervised Community Care Application

The Supervised Community Care Plan is to be completed by the Community Mental Health Care Liaison and sent to Psychiatric Patient Advocate Services. Fax Number: (506) 462-2230

Name:____ Medicare Number: ____________________

Address:____

Phone number:______________________________ DOB(MM/DD/YYYY):_______/_______/_____________

Gender – Select ONE only:

- ❑ Female
- ❑ Male
- ❑ Transgender – Female to Male
- ❑ Transgender – Male to Female
- ❑ Intersex
- ❑ Other: Please specify ______________________________
- ❑ Prefer not to answer
- ❑ Do not know

Ethnicity (which of the following best describes the client/patient's racial or ethnic group? Select ONE only.

- ❑ Asian – East (e.g. Chinese, Japanese, Korean)
- ❑ Asian – South (e.g. Indian, Pakistani, Sri Lankan)
- ❑ Asian – South East (e.g. Malaysian, Filipino, Vietnamese)
- ❑ Black – African (e.g. Ghanaian, Kenyan, Somali)
- ❑ Black – Caribbean (e.g. Barbadian, Jamaican)
- ❑ Black – North American (e.g. Canadian, American)
- ❑ First Nations
- ❑ Inuit
- ❑ Metis
- ❑ Indigenous / Aboriginal not included elsewhere
- ❑ Latin American (e.g. Argentinean, Chilean, Salvadorian)
- ❑ Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
- ❑ White – European (e.g. English, Italian, Russian, Portuguese)
- ❑ White – North American (e.g. Canadian, American)
- ❑ Mixed heritage (e.g. Black-African and White-North American)
- ❑ Other: Please specify ___________________
- ❑ Do not know
- ❑ Prefer not to answer

Guardian and Custody Status (if applicable):

- ❑ Lives with both parents
- ❑ Joint Custody (both parents need to be aware and consenting)
- ❑ Sole custody
- ❑ Client lives independently
- ❑ Other: Please specify ____
- ❑ Not-applicable

Originating Location of Referral:

❑ Hospital – inpatient ❑ Hospital – emergency room

❑ Mental Health Centre ❑ Other_______________________________

Primary Diagnosis

❑ Schizophrenia
❑ Schizoaffective Disorder
❑ Bipolar Disorder
❑ Other
- ❍ Substance/Alcohol Abuse Disorder
- ❍ Personality Disorder
- ❍ Depression
- ❍ Other Psychotic Disorder: _______________________________
- ❍ Other Disorder: _______________________________

Consent Model

❑ Individual consented to SCC
❑ Substitute Decision Maker consented to SCC
❑ Psychiatric Application / Non-Consent Model

Preferred language

❑ English ❑ French ❑ Other: Please specify _______________________________

Treating psychiatrist

Name:_______________________________ Agency:_______________________________

Phone number: _______________________________ Email: _______________________________

Substitute Decision Maker, if applicable

Name: _______________________________ Relation: _______________________________

Address: _______________________________

Phone number: _______________________________ Email: _______________________________

Support Person to Individual on SCC, if applicable

Name: _______________________________ Relation: _______________________________

Address: _______________________________

Phone number: _______________________________ Email: _______________________________

Support Person to Individual on SCC, if applicable

Name: _______________________________ Relation: _______________________________

Address: _______________________________

Phone number: _______________________________ Email: _______________________________

PART II

Supervised Community Care Plan

The Supervised Community Care Plan is to be completed by the Community Mental Health Care Liaison and sent to Psychiatric Patient Advocate Services. Fax Number: (506) 462-2230

Name: ______________________________

Medicare Number: ______________________ Date of Birth (MM/DD/YYYY): ____/____/______

Address:______________________________

Substitute Decision Maker, if applicable

Name: ______________________ Relation: ______________________

Address: ______________________________

Phone number: ______________________ Email: ______________________

Support Person to Individual on SCC, if applicable

Name: ______________________ Relation: ______________________

Address: ______________________________

Phone number: ______________________ Email: ______________________

Support Person to Individual on SCC, if applicable

Name: ______________________ Relation: ______________________

Address: ______________________________

Phone number: ______________________ Email: ______________________

Eligibility Criteria/ Conditions (34.01)

Person is suffering from a serious mental illness that is; (must meet all 3 criteria)

- ❑ Continuous in nature
- ❑ Severely limits the person's functioning in the community
- ❑ Requires care and treatment

______________________________ ______________________________

(Signature of Assessing Psychiatrist) *(Date)*

(PSYCHIATRIST'S NOTES)

(PSYCHIATRIST'S NOTES)

Notes: S.34.01 After evaluating a person who is suffering from a serious mental illness, a psychiatrist may establish a supervised community care plan for the person, if the person meets the following conditions:

a) The person is suffering from a serious mental illness that

i. Is continuous in nature,

ii. Severely limits the person's functioning in the community, and

iii. Requires care and treatment

b) The person is a patient or former patient who was admitted to a psychiatric facility or, in the opinion of the psychiatrist, the person has a pattern of behavior while living in the community demonstrates that, because of the serious mental illness, the person is likely to cause serious harm to himself or herself or another person or to suffer substantial mental or physical deterioration.

Consent (34.02)

Consent to a supervised community care plan is required by one of the following three options:

❑ The person who is subject to the plan

(Signature of Individual) *(Date)*

OR

❑ The substitute decision maker (34.02.1)

(Signature of Substitute Decision Maker) *(Date)*

OR

❑ Psychiatric application to review board in absence of consent (34.02.2)

(Signature of Psychiatrist) *(Date)*

(PSYCHIATRIST'S NOTES)

Notes: S.34.02(1) Consent to a supervised community care plan is required from the person who is subject to the plan, or in the case of a person who is not mentally competent, by the substitute decision-maker under section 8.6

S.34.02(2) Despite subsection (1), a psychiatrist may make an application to the review board having jurisdiction to have a person who is not mentally competent be made subject to a supervised community care plan in the absence of consent by the substitute decision-maker it the psychiatrist is of the opinion that it is in the best interests of the person.

Detailed Care Plan (34.04)

Attending appointments/community based services

The following is required:

Appointments/Community Services	Service Location	Frequency

Additional comments:

Medications

The following is required:

Medications	Dosage	Routine

Additional comments:

Housing

The following is required regarding housing:

Health Professionals involved with this care plan:

Name and Position	Contact Info	Obligations

Additional content of individuals care plan not covered previously if applicable:

Duration of plan (34.03)

The terms of this care plan are required and will be reviewed yearly, or before, the anniversary of the review board hearing with the availability for 1 additional review board hearing per year. A total of two reviews are possible each year. If you wish to make an amendment to your care plan, speak to a member of your health care team.

Copy of plan (34.05)

The following members of this persons care plan team have received a copy of this form:

Person subject to plan:

Signature: ______________________ Date received: ______________

Substitute Decision maker if applicable:

Signature: ______________________ Date received: ______________

Support Person or Persons if applicable:

Signature: ______________________ Date received: ______________

Signature: ______________________ Date received: ______________

Signature: ______________________ Date received: ______________

Treating Psychiatrist:

Signature: ______________________ Date received: ______________

All other healthcare professionals named in the plan:

Signature: ______________________ Date received: ______________

Signature: ______________________ Date received: ______________

Signature: ______________________ Date received: ______________

Signature: ______________________ Date received: ______________

Any other individuals involved in the care plan:

Signature: ______________________ Date received: ______________

Signature: ______________________ Date received: ______________

Signature: ______________________ Date received: ______________

Signature: ______________________ Date received: ______________

Failure to comply with care plan (34.06)

Notes:S.34.06(1) A psychiatrist who has reasonable grounds to believe that a person who is subject to a supervised community care plan is not meeting his or her obligations under the plan shall

a) Make reasonable efforts to inform the person or the substitute decision-maker, if applicable, and

b) Provide reasonable assistance to the person to enable him or her to meet his or her obligations

S.34.06(2) A psychiatrist may issue a certificate of non-compliance with a supervised community care plan if her or she considers it appropriate

S.34.06(3) A certificate under subsection (2) expires 30 days after its issuance

S.34.06(4) A certificate under subsection (2) is sufficient authority for a peace officer to take into custody the person named in the certificate without a warrant, and to take that person to a medical facility, psychiatric facility or physician's office where the person may be detained for medical examination

Failure to comply with the plan (34.06)

If a psychiatrist had grounds to believe the person is not following their care plan, they, or a member of the care team, must make reasonable effort to inform the individual of the failure to follow the plan, make reasonable effort to help them follow the plan, and explain the consequences for not adhering to the plan If the individual does not follow the plan, the psychiatrist can issue a certificate of non-compliance which gives a peace officer sufficient authority to escort the individual named in the plan to a health facility for further medical assessment The certificate lasts 30 days, and if the individual is not assessed within those 30 days the individual is off the plan.

By signing below, there is agreement and understanding of the aforementioned conditions, the obligations and duty to uphold them as well as the consequences to not following the Supervised Community Care Plan.

____ ________________________

(Signature of Individual or Substitute Decision Maker) *(Date)*

____ ________________________

(Signature of Treating Psychiatrist) *(Date)*

Psychiatric Patient Advocate Services while under Supervised Community Care Plan:

Psychiatric Patient Advocate Services (PPAS) are made aware of all Supervised Community Care Plans under the *Mental Health Act*. Psychiatric patient advocates meet, confer with, provide advice and assist all persons under Supervised Community Care plans.

PPAS advocates assist persons subject to Supervised Community Care Plans in understanding the *Mental Health Act,* as well as their rights. They will assist in any requests for inquiry into the Supervised Community Care provision as well as help the person prepare for and be present at all Review Board hearings.

To request information pertaining to the *Mental Health Act,* and more specifically regarding Supervised Community Care Plan as well as to request inquiry with the *Mental Health Act* Review Board, contact PPAS by phone.

Psychiatric Patient Advocate Services of N.B.
(506)-869-6818 or Toll free: 1-888-350-4133
Fax Number: (506)-462-2230

By signing below, there is agreement and understanding of the role of the Psychiatric Patient Advocate Services.

____ ________________________

(Signature of Individual or Substitute Decision Maker) *(Date)*

____ ________________________

(Signature of Treating Psychiatrist) *(Date)*