GOVERNMENT OF BERMUDA
Ministry of Health

Bermuda Hospitals Board

Mental Health Act Review

Proposed Amendments to Mental Health Act

V1.0, 06 February 2018

Consultation Paper

Closing date for comments: 28 February 2018

Table of Contents

1.0 Executive Summary

This paper outlines recommendations for urgent changes to the **Mental Health Act 1968** (the "**Act**") developed by key stakeholders. This initial phase of urgent changes will be followed by a complete review of the entire legislation. The recommendations provided in this paper are modelled off of the United Kingdom's Mental Health Act, the foundation of Bermuda's legislation, and incorporates aspects of United Kingdom's Mental Capacity Act 2005. The following is a summary of the urgent changes proposed for this phase of amendments:

1.1. Role of the Nearest Relative for patient admission

Develop a Code of Practice to provide guidance to mental health professionals on admission processes of patients to hospital. This Code will require the Mental Welfare Officer to sign the admission forms upon consultation with the Nearest Relative. This removes the practice of the Nearest Relative signing the admission form which can result in non-admission due to the nearest relative's fear of damaging their relationship with their loved one. This proposal is the current practice in the UK.

1.2. Establishment of Community Treatment Orders

Introduce provisions under the Act for Supervised Community Treatment in the form of Community Treatment Orders ("CTO"). CTOs enable mental health professionals to treat patients granted leave from the hospital for extended periods of time. This amendment will enable conditions to be set for patients to live in the community (such as continuation of medication) while also improving legal safeguards to protect the rights of the patient.

1.3. Ensuring Consent to Treatment is obtained

Establish safeguards under the Act for patients regarding Consent to Treatment. The Act currently does not provide legal safeguards for patients who either cannot consent or refuse to consent to treatment. Provisions for Consent to Treatment recommended will apply to all detained patients whether in hospital for treatment or living in the community under the CTO provisions proposed.

1.4. Requirements to define and determine Mental Capacity

Introduce provisions under the Act for determining Mental Capacity. A patient cannot consent to or refuse treatment unless they have the Mental Capacity to do so. The Mental Capacity provisions recommended will define a person who lacks capacity, outline a framework for assessing whether a person is unable to make a decision and therefore lacks capacity, and ensure decisions taken for those who lack capacity are done so in that person's best interests.

1.5. Feedback on the proposals in this paper should be provided as outlined in the Consultation Requirements section by 28th February 2018.

2.0 Introduction – The Case for Change

"*The Mental Health Act's focus is on protecting the rights of persons for whom involuntary assessment, treatment and care is necessary*."[1]

2.1 Bermuda's Mental Health Act 1968 is modelled after the UK's 1959 Mental Health Act. Since 1959, the UK introduced an entirely new Mental Health Act in 1983; significant amendments in 2007; and are about to embark on further changes to keep pace with advancements in mental health treatment and other evolving patterns in modern healthcare.

2.2 The Bermuda Act was last amended almost 20 years ago in 1998. Since then models of care and methods of treatment have advanced significantly with increasing recognition that social care is a key element in the treatment and support of those with mental disorders. There has also been increased recognition of patient rights particularly around issues of capacity and consent to treatment. As a result the legislation must be updated to reflect such changes.

2.3 The Project Team established to review the Mental Health Act 1968 note that:

- The Act, while functional, is in need of significant change;
- There is general acknowledgement that **the UK Mental Health Act** ("**UK MHA**") and the **UK Mental Capacity Act** ("**UK MCA**") are good pieces of legislation and that the Bermuda Mental Health Act should take its lead from these documents;
- That a wholesale import of the UK MHA and the UK MCA is not appropriate, rather key principles adopted from this legislation should be customized to fit Bermuda's needs.

2.4 While it is widely recognized that a wholesale review and re-write of the Act is required, doing so will take considerable time and will delay resolving several issues in urgent need of attention. Accordingly the Steering Committee adopted a phased approach:

- Phase I – to address matters requiring urgent attention
- Phase II - wholesale re-write of the MHA to immediately follow Phase I.

2.5 The urgent matters identified in Phase I include:

- Role of the Nearest Relative
- Community Treatment Orders
- Consent to Treatment
- Mental Capacity

2.6 Please see **Appendix A** for a summary of the Policy Development and Consultation Process.

[1] Tasmania's Mental Health Act 2013 - A Guide for Clinicians, Tasmania Department of Health and Human Services

3.0 Adaptation Considerations

The UK MHA and UK MCA must be adapted to fit with Bermuda legislation and available resources. Accordingly, the following adaptations with regard to scope, terminology and roles have been made to align with our service structure and purpose of this phase of amendments:

Terminology and proposed roles

3.1 The following outlines the roles used in the UK MHA and the proposed roles to perform their functions within Bermuda's system:

UK Mental Health Act	**Bermuda Health System** (proposed equivalent)
Appropriate Authority, or Regulatory Authority	To be appointed by the Minister
Approved Clinician	Responsible Medical Officer
Approved Mental Health Professional	Mental Welfare Officer
Independent Registered Medical Practitioner (also known as a Second Opinion Approved Doctor (SOAD))	Designated Registered Medical Practitioner
Registered Medical Practitioner	Registered Medical Practitioner (i.e. registered by the Bermuda Medical Council)
Responsible Clinician	Responsible Medical Officer

Role of the Appropriate Authority, Regulatory Authority and Independent Registered Medical Practitioner

3.2 The proposed amendments to the Act introduce two roles not currently specified in the Bermuda mental health system:

- A specific regulatory (or appropriate) authority, and
- Designated Registered Medical Practitioner

These roles are required to provide independent oversight in specific circumstances and are a key element to certain safeguards being introduced to protect the rights of patients detained under the Act. Those acting in the role of a Designated Registered Medical Practitioner will be required to have appropriate clinical expertise.

Persons Under 18 Years of Age

3.3 The proposed legislative amendments to the Act as outlined in this consultation paper are to apply only to those persons over 18 years of age, consistent with the UK Mental Capacity Act 2005 which applies to adults only.

3.4 UK legislation makes reference to persons who are 16 years of age and older. Once a child reaches the age of 16 they are presumed in law to be competent and to have capacity and be able to consent or refuse treatment in their own right. The UK Mental Capacity Act 2005 does not apply to children under 16 years of age.

3.5 In Bermuda the equivalent age as established under the Children Act 1998 is 18 years of age. Accordingly, when adapting key principles from the UK legislation to the Bermuda framework as outlined in the tables that follow, all references to persons 16 years of age have been modified to read as 18 years of age.

3.6 Guidelines for determining a child's competency and capacity to consent to treatment have not been considered during this phase of amendments. These issues require considerable research and consultation and will be addressed as part of the broader Phase II review of the Act.

Scope of Proposed Amendments

3.7 The key principles recommended in this consultation paper are limited and are intended for application specific to the Act; whereas the same principles the UK legislation may have a much broader scope and application. For example, the UK Mental Capacity Act is not restricted to mental health treatment. Although broader mental capacity legislation is required in Bermuda, to move ahead with urgent amendments as expediently as possible, the scope of the capacity framework proposed is tied only to treatment under the Act.

Code of Practice

3.8 The UK has developed Codes of Practice to provide practical guidance for carers and practitioners on how to best apply mental health legislation on a day-to-day basis. Separate Codes of Practice have been developed for the UK Mental Health Act 1983 and the UK Mental Capacity Act 2005.

3.9 For the purposes of this amendment, references to the "Code" shall mean a single code of practice specific to the Act that will be developed in phases. The first phase will focus on matters under this set of amendments.

4.0 Proposed Changes

4.1 Role of the Nearest Relative

This recommendation represents a change in policy only.

Background

4.1.1. In Bermuda the Nearest Relative plays a critical role with regard to admitting and discharging patients detained in hospital for treatment.

4.1.2. Under Section 11(1) an application for admission for either assessment or treatment may be made by either a **Mental Welfare Officer ("MWO")** or by the Nearest Relative. Furthermore, under Section 11(2), an application for admission for treatment shall not be made by Mental Welfare Officer except after consultation with the Nearest Relative, or if the Nearest Relative notifies that Mental Welfare Officer or the Board that he/she objects to the application being made.

4.1.3. Under Section 26(2)(b) a patient admitted for treatment can be discharged if an order for discharge is made by the responsible medical officer, by the Chief of Psychiatry, or by the Nearest Relative of the patient.

Issue

4.1.4. There are a number of issues that arise with the role of the Nearest Relative under the Act. Issues identified include:

- The Nearest Relative may not have the patient's best interest at heart.
- The role of the Nearest Relative can cause significant distress to families when asked to commit a family member to treatment and detention, such as:
  - Rifts within families resulting in decisions not in the patient's best interest, including blocking admission.
  - Reinforcement of a patient's delusional beliefs about family members when they find out they are responsible for their admission.
  - Fear of repercussion by patient and therefore unwilling to sign the admission paperwork.
- In Bermuda, there are frequent occurrences with a Nearest Relative objecting to treatment for their family member when it may not be in the best interest of the patient.

Solution

> ***Develop a Code of Practice to provide guidance for Bermuda's mental health professionals on admissions processes of patients to hospital.***

4.1.5. The UK and other jurisdictions with similar legislation enact the legislative framework differently than Bermuda that can be used to address this issue. Under Bermuda law the Mental Welfare Officer or the Nearest Relative may sign the application for admission for treatment. This follows UK law where an Approved Mental Health Professional ("AMHP") or the Nearest Relative may sign the application. However, in Bermuda, the MWO will consult with the Nearest Relative, complete an application for admission for treatment then ask the Nearest Relative to sign the application. In the UK, the AMHP will consult with the Nearest Relative then, with the knowledge that the Nearest Relative has no objection, complete and sign the application. The difference in application of the law lies in the UK Code of Practice where the AMHP is considered the more appropriate person to sign the application, "…given their professional training and knowledge of the legislation and local resources. This also removes the risk that an application by the nearest relative might have an adverse effect on their relationship with the patient."[2]

4.1.6. Adopting a Code of Practice in Bermuda, similar to that used in the UK may decrease the number of Nearest Relative objections by removing the burden of being responsible for committing a family member to hospital. The Nearest Relative will still have authority to object and block admission, but the burden of having to sign the application will be removed. The MHA Steering Committee recognizes that this solution does not address all issues with the definition and role of the nearest relative, nor will it prevent all objections, but it will:

- Maintain a fundamental patient safeguard in the role of the Nearest Relative.
- Address some (but not all) of the key factors resulting in objection.
- Create a change in practice via policy and allow opportunity to determine further if more substantive legislative changes are required.

See Table 4.1 for a summary of key policies from the UK Code of Practice to be considered for adoption.

[2] UK Mental Health Act 1983: Code of Practice published in 2015; Chapter 14 Applications for Detention in Hospital, section 14.30.

Table 4.1 - Nearest Relative

UK MHA Code of Practice Reference	Summary
Chapter 14 Applications for Detention in Hospital	**Applications for Detention** Chapter 14 of the UK Code of Practice covers all aspects of the application process for patients admitted to hospital in the UK. Only key sections relevant to role of the Nearest Relative are included in this table.
Sections **14.4 – 14.25** Criteria for Applications for Assessment or Treatment	**Defines criteria for Applications** - To admit patient for assessment (s.14.4) - To admit patient for treatment (s.14.5) Defines factors to consider regarding health and safety of the patient.
Sections **14.30 – 14.48** Assessment Process	**Assessment Process** Provides guidance to AMHP to complete application for detention. Guides AMHP to complete and sign application based on training and knowledge of the legislation (s.14.30)
Sections **14.49 – 14.76** Role of the Approved Mental Health Professional (AMHP)	**Requirements of AMHP** - Steps AMHP must follow when making an application for detention (s. 14.49) - When AHMP must make application for detention (s. 14.50) - Requirement to consult Nearest Relative prior to making application for admission for treatment (s.14.59) - Matters to discuss with the Nearest Relative (s.14.64)

Please see the following Reference Documents for further details:

- Bermuda Mental Health Act 1968, sections 8, 10, 11
- UK Mental Health Act 1983, sections 3, 11, 26
- UK Mental Health Act 1983, Code of Practice, chapters 4, 5, 14

4.2 Community Treatment Orders

Background

4.2.1 Section 20 of the Bermuda MHA allows for the **Responsible Medical Officer ("RMO")** to grant any patient leave from hospital, subject to conditions that the RMO considers necessary in the interests of the patient or for the protection of other persons. Such conditions typically include that a patient abstain from consumption of certain substances (i.e. drugs and alcohol) and that patients continue with any drug treatments prescribed by the RMO. Where a patient is discovered to be in breach of conditions established as part of their prescribed leave of absence, or if it appears to the RMO that it is necessary to do so in the interest of the patient's health or safety, or for the protection of other persons, the RMO may revoke the leave of absence and recall the patient to hospital. Patients who comply with all conditions of their leave, are in a healthy state, and pose no risk to themselves or others give no reason to be recalled to hospital and typically complete their leave of absence without issue. After the expiration of 12 months from the first day of his/her absence from hospital, patients cease to be liable for detention in hospital. The RMO may recommend the patient continue with prescribed medication and avoidance of drugs or alcohol; however the threat being recalled to hospital for non-compliance is removed.

Issue

4.2.2 Bermuda's current legislation prioritizes hospital detention as opposed to more modern community based living and treatment.

4.2.3 There are many cases where patients have successfully completed their leave of absence; however after this period they stop taking their medication and/or start again with drugs or alcohol. This can result in a slow deterioration and relapse, possibly becoming a risk to themselves or others and ultimately requiring that they be re-admitted to hospital again for treatment. There is a repetitive cycle of admission to hospital / treatment / leave of absence / relapse / re-admission for some patients. A recent example is a patient who has completed this cycle 17 times.

Solution

> ***Introduce provisions under the Act for Supervised Community Treatment in the form of Community Treatment Orders.***
> **Means**: Amend the Act to provide for extended leave from hospital together with treatment under Community Treatment Orders similar to those found in sections 17A through 17G and sections 18, 20 and 21 of the UK MHA 1983 as outlined in Table 2.

4.2.4 The United Kingdom introduced the **Community Treatment Orders** (**CTO**) as part of the 2007 amendments to the UK Mental Health Act of 1983. The introduction of the CTO was controversial as it opens the possibility to subjecting patients to indefinite compulsory treatment after they had been discharged from hospital. However, the UK government appears to have found a balance between the need for compulsory treatment outside of a hospital setting and the need to protect the human rights of patients subject to CTOs (see Sections 17A – 17G and Section 20 of the UK Mental Health Act 2007, Appendix C).

4.2.5 Key aspects of the CTO are:

- Patients are permitted to live in the community subject to certain conditions that may include: where they may live, compliance with prescribed medication, abstinence from illicit drugs and/or alcohol and participation in regular drug screenings.
- The CTO can be granted for a period of up to 6 months at which time it can be renewed for a further six month period and again thereafter in 12 month increments for as long as may be required.
- Safeguards are in place to protect the patient including: formal reviews at each time a CTO is renewed; and the right to a Mental Health Review Tribunal hearing within the first six months from the date the CTO was made and during each period of renewal should the patient wish to be discharged from the CTO.

4.2.6 CTOs are not required for all patients, and in Bermuda it is expected that use of such would be limited to a select number of patients who frequently repeat the cycle of admission.

4.2.7 While it could be argued that requiring a patient to continue living under certain restrictions is depriving them of their basic human rights, providing them the opportunity to live in the community under a supervised CTO (and therefore not in hospital) allows the patient to enjoy a fuller life while maintaining their health in exchange for their taking personal responsibility for their own health through compliance with the conditions of their CTO.

4.2.8 Components of the UK MHA as presented in Table 4.2 are proposed to be included within Bermuda's legislation:

Table 4.2 - Community Treatment Order

UK MHA Reference and Summary	Key Principles Proposed for Bermuda MHA
Section 17(2A),(2B) Defines when 'longer-term' leave may be granted	**Longer Term Leave** • Section 17 of UK MHA covers Leave of Absence from Hospital (equivalent to section 20 under Bermuda MHA) • Longer-term leave is: - Leave granted either indefinitely or for a specified period greater than 7 consecutive days. - A specified period is extended such that the total period of such leave is greater than 7 consecutive days. • Longer-term leave may not be granted unless the Responsible Clinician (RC) first considers whether patient should be dealt with under CTO (pursuant to s.17(A))
Section 17A Criteria that must be met in order for a Responsible Clinician to order a CTO.	**Criteria for CTO** • RC may by order discharge detained patient from hospital under CTO. • Patient however remains liable to recall. • CTO Requires: - RC opinion that criteria are met; - Approved Mental Health Professional (AMHP) agrees with RC opinion and that CTO is appropriate • Criteria: - Patient suffering from mental disorder for which medical treatment is appropriate - Treatment is necessary for patient's health or protection of others. - Treatment can be provided without need to be detained in hospital. Having regard to patient's history and risk of a patient's deterioration of condition; RC should be able to exercise power to recall patient to hospital if necessary.
Section 17B CTO required to specify conditions to which patient is to be subject while the CTO remains in force.	**Specified Conditions** • Required Conditions: - Patient must be available for examination as required for the following purposes: ▪ To extend the CTO ▪ To enable an independent Registered Medical Professional (RMP) to certify it is appropriate for the specified treatment to be given or to be given subject to specified conditions. • Additional conditions may be specified by RC, if agreed to by AMHP, to: - Ensure patient receives medical treatment - Prevent risk of harm to patient - Protect other persons • RC may: - vary conditions from time to time - suspend conditions - consider non-compliance by patient for purposes of recall.

Table 4.2 - Community Treatment Order

UK MHA Reference and Summary	Key Principles Proposed for Bermuda MHA
Section 17C Circumstances when CTO ceases to have effect. Reference to Section 20 for specified periods of enforcement.	**When CTO Ceases to Have Effect** • CTO remains in force until earlier of: - expiry of 6 months from date issued (subject to extension), - patient is discharged, - application for admission for treatment of the patient ceases to have effect, - CTO is revoked.
Section 17D Extends treatment out of hospital into the community.	**Effect of CTO** • Admission for treatment remains in effect under a CTO. • Authority to detain patient remains in effect but is suspended while patient discharged under CTO.
Sections 17E – 17F Recalling patient to hospital.	**Recall** • RC may recall patient if: - Patient requires medical treatment in hospital; and - There is risk of harm to the patient or others if patient not recalled. • Patient may also be recalled if patient fails to comply with specified conditions of CTO. • RC may revoke CTO if: - Conditions for application for admission for treatment are met, and - AMHP agrees with opinion of RC and it is appropriate to revoke the order. • Patient may be released if CTO not revoked. • Patient must be released if patient has not been released or CTO revoked within 72 hours of recall. • If released, patient remains subject to CTO.
Section 17G Revoking CTO has affect as if patient had never been discharged from hospital.	**Revoking CTO** • When CTO is revoked: - Authority to detain patient shall have effect as if patient had never been discharged from hospital. - Patient liable to be detained pursuant to an application for admission to hospital for treatment as they did before CTO order was made.

Table 4.2 - Community Treatment Order

UK MHA Reference and Summary	Key Principles Proposed for Bermuda MHA
Sections 18(2A),(4),(4A),(4B) Return and readmission of patients absent without leave and powers to do so.	**Absent Without Leave** • Where patient under CTO (**Community Patient**) is absent from hospital to which patient has been recalled, patient may be taken into custody and returned to hospital by: - any AMHP, - any officer on staff of the hospital, - any police officer. - by person(s) authorized in writing by RC of the hospital. • Power to do so expires at earlier of: - end of 6 month period from first day of patients absence without leave, and - end of period for which CTO is in force. • Extension of a CTO while a patient is absent without leave shall not be valid for this purpose.
Section 21(4); 21A(1),(4),(5); 21B Special provisions for patients absent without leave	**Special Provisions – Absent Without Leave** • Community Patient recalled to hospital must be released or CTO must be revoked within 72 hours of time when admitted under recall (s. 17F). - If patient is absent without leave (AWOL) at time when 72 hour limit expires, the 72 hour time period recommences at the time when patient returns or is returned to hospital. • Patients AWOL and return within 28 days: - Time period required for patient examination by RC is extended. - Community treatment period may also be extended if required. • Patients AWOL for more than 28 days: - Within one week of returning to hospital the RC must: ▪ Examine patient ▪ Furnish a report ▪ Inform patient - If patient liable to be detained or CTO to remain in effect (i.e. not revoked), RC must also consult: ▪ One or more other persons professionally concerned with patient ▪ An AMHP

Table 4.2 - Community Treatment Order

UK MHA Reference and Summary	Key Principles Proposed for Bermuda MHA
Section 20A, 20B Time limits of CTO's, periods of extension, and expiry.	**Time Limits and Extensions** • CTO shall be in effect for: - 6 month period beginning on dated CTO is made • Provided CTO has not expired, it may be extended - For a period of 6 months; - For a further 12 month period and so on for periods of one year at a time. • Within 2 months ending on date CTO would expire, RC must: - Examine patient - Submit report to hospital managers describing patient condition supported by: ▪ a statement by a AMHP that: o Patient is suffering from a mental disorder and it is appropriate that they receive treatment o Treatment is necessary for health and safety of patient and protection of other persons o Such treatment can be provided without patient being detained in hospital o It is necessary for RC to continue to be able to recall patient to hospital ▪ Statement from AMHP that it is appropriate to extend CTO period. ▪ Consultation with one or more other persons professionally concerned with patients medical treatment. • Upon expiry of a CTO: - Patient deemed to be discharged absolutely (i.e. no longer subject to recall), and - Patient's application for admission for treatment shall cease to have effect (i.e. no longer liable to be detained).

Please see the following Reference Documents for further details:

- Bermuda Mental Health Act 1968, sections 20 – 22
- UK Mental Health Act 1983, sections 17 – 21
- UK Mental Health Act 1983, Code of Practice, chapters 27 – 29, 31

4.3 Consent to Treatment

Background

4.3.1 Section 15 of the Act grants authority to a RMO to order that a patient, who has been admitted to hospital for treatment:

- Be subjected to such treatment as may be necessary for the medical and psychiatric care and welfare of the patient,
- For such treatment to be administered by the staff of the hospital, and
- For staff to use such force as may be necessary in the circumstances to effect any of those purposes.

4.3.2 The Act does not address one of the fundamental issues of modern day healthcare; the patient's right to consent to treatment. Equally important, the Act provides no guidance on when and under what circumstances a patient can be subjected to treatment when they have objected to such treatment. The Mental Health Review Tribunal can be appealed to regarding such decisions and has recently indicated the urgency of improving the legislation in this area.

Issue

4.3.3 The Act does not provide the following:

- The right for the patient to consent to treatment
- Safeguards for patients who do not consent to treatment
- A clear authority (together with necessary guidelines) to mental health professionals to prescribe treatment without consent in cases where a patient is not capable of understanding the nature, purpose and likely effects of the proposed treatment.

4.3.4 This perhaps is one of the more important amendments proposed in this consultation paper. Without clear guidance with regard to consent to treatment, a patient, the mental health service providers who treat them and possibly others may be at risk of harm should there be undue delay in treatment caused by a patient objecting and seeking a judicial review of the decision to administer treatment against his/her will.

Solution

> ***Establish safeguards under the Act for patients regarding Consent to Treatment.***
>
> **Means**: Amend the Act to include provisions for Consent to Treatment similar to those found in sections 57 - 64 of the UK MHA 1983 as outlined in Table 3.

4.3.5 The UK addressed this issue in their 1983 and 2007 amendments as outlined in Table 4.3 below.

Table 4.3 - Consent to Treatment

UK MHA Reference and Summary	Key Principles Proposed for Bermuda MHA
For Patients: Detained in Hospital; on CTO and recalled to Hospital; or CTO revoked	
Section 57 Treatment requiring consent and a second opinion (i.e. Psychosurgery)	**Treatments that require consent and a second opinion** • Any surgical operation for destroying brain tissue or the functioning of brain tissue (Psychosurgery). • Unless classified as urgent treatment, patient shall not be given Psychosurgery unless: - Patient has consented to the treatment, and - An appointed independent Registered Medical Practitioner (RMP) and two other appointed persons (not being RMPs) certify that patient is capable of understanding nature, purpose and effects of treatment and has consented to it, and - Appointed RMP, after consulting two other professionals concerned with patient's medical treatment, certifies it is appropriate that treatment be given. The two professionals being: ▪ A nurse and the other neither a nurse nor a RMP; and ▪ Neither shall be the RC in charge of the treatment in question.
Section 58 Medication Administration Requiring Consent or a Second Opinion including circumstances when patient is not capable of consenting to treatment.	**Treatments that require consent or a second opinion** • Unless classified as urgent treatment, administration of medicine by any means of treatment at any time after 3 months or more have elapsed since the first occasion when medicine was administered to patient requires the following: - Patient shall not be given treatment unless: ▪ Patient has consented to that treatment, and the RC in charge of treatment or an appointed independent RMP certifies that patient is capable of understanding its nature, purpose and effects and has consented to it; or ▪ Appointed independent RMP certifies that patient is not capable of understanding nature, purpose and effects or has not consented to it, but it is appropriate to give treatment. - Prior to giving certificate, RMP must consult two other professionals concerned with patients medical treatment being: ▪ A nurse and the other neither a nurse nor a RMP; and ▪ Neither shall be the RC in charge of the treatment in question.
Section 58A Electroconvulsive Therapy ("ECT"). Requirements for ECT to be used as treatment.	**Electroconvulsive Therapy** ECT and medication administered as part of ECT must not be given unless: • Patient has consented to treatment, and • RC or appointed independent RMP certifies that patient is capable of understanding nature, purpose and effect of treatment and has consented to it. • For patients who lack capacity: - Appointed independent RMP must certify: ▪ Patient is not capable of understanding nature, purpose and effect of treatment, but ▪ It is appropriate that treatment be given. - Certification subject to RMP consulting with two persons professionally concerned with patient's medical treatment being: ▪ A nurse and the other neither a nurse nor a RMP, and ▪ Neither is the RC or clinician in charge of the treatment in question.
Section 59 Plans of Treatment. Links consent and certificates to plans of treatment.	**Plans of Treatment** • Any consent or certification under s.57, s.58 and s.58A may relate to a plan of treatment under which patient is to be given one or more forms of treatment.

Table 4.3 - Consent to Treatment

UK MHA Reference and Summary	Key Principles Proposed for Bermuda MHA
Section 60 and 62(2) Required Actions when Patient Withdraws Consent	**Withdrawal of Consent** • Patients may withdraw their consent at any time. • If patient gives consent but before completion of treatment ceases to be capable of understanding nature, purpose and effect of treatment, patient must be treated as if they have withdrawn consent. • Where consent withdrawn or where patient no longer capable of understanding treatment, remainder of treatment is considered a separate form of treatment. • If having not previously been capable of consent and a certificate was used to proceed with treatment and patient becomes capable of consent prior to completion of treatment, certificate shall cease to apply and treatment must be considered a separate form of treatment. • Separate form of treatment must then follow provisions for consent as required under the Act. • Treatment may be continued if RC considers discontinuing it would cause serious suffering to the patient.
Section 61 When report on patient's condition required by the Regulatory Authority.	**Required Reports** • A report on the treatment and patient's condition must be given by the RC to the Regulatory Authority (**RA**) under the following circumstances: - Treatment requiring consent and a second opinion (s. 57) - Treatment requiring consent or a second opinion where patient is not capable of consenting to treatment - ECT treatment where patient is under 18 years of age or is not capable of consenting to ECT - Treatment on recall of patient under a CTO or revocation of a patient's CTO. • Reports must be submitted to RA: - Whenever requested by the RA - On next occasion when RC must report to hospital managers to renew patient's detention, extend a CTO, or confirm detention or CTO of patients absent without leave for more than 28 days. • For patients subject to a restriction order: - A report at the end of the 6 month period from start of the order - Subsequent reports at intervals required by the Regulatory Authority from time to time.
Section 62 Urgent treatment when consent not required.	**Urgent Treatment** • Except for ECT, consent not required if treatment is: - Immediately necessary to save patient's life - Not being irreversible, is immediately necessary to: ▪ prevent serious deterioration of patient's condition ▪ alleviate serious suffering ▪ prevent patient from harming himself or others • Consent for ECT not required if treatment is: - Immediately necessary to save patients life - Not being irreversible is immediately necessary to prevent serious deterioration of patient's condition.
Section 62A Criteria for treatment when CTO patients are recalled to hospital, or if CTO revoked.	**CTO Recall or Revocation** • Applicable only to treatments that require consent or a second opinion under sections 58 and 58A. • If recalled to hospital (or CTO is revoked), patient is treated as they were detained in hospital pursuant to their admission to hospital for treatment. • Standard consent procedures apply unless a certificate was issued by a RMP while patient was on CTO specifying treatment as being appropriate which enables treatment to be continued while patient on recall at hospital. • When CTO is revoked, treatment based on RMP certificate under the CTO may continue until a new certificate can be arranged, applicable to patients admitted to hospital for treatment.

Table 4.3 - Consent to Treatment

UK MHA Reference and Summary	Key Principles Proposed for Bermuda MHA
Section 63 Treatment not Requiring Consent by virtue of elimination of those requiring consent above.	**Treatment where consent not required** • Consent of patient not required for medical treatment given for the mental disorder from which patient suffers, provided such treatment: - Does not fall under requirements of: ▪ s.57 (psychosurgery), ▪ s.58 (prolonged treatment by administration of medicine) ▪ s.58A (electroconvulsive treatment) - Is given under direction of an Approved Clinician.
For Patients: In community on CTO not recalled to hospital	
Section 64A Medical Treatment allowed under CTO	**Treatment allowed under CTO** • Relevant treatment is medical treatment which: - Is for the mental disorder from which the patient is suffering, and - Is not a form of treatment that falls under section 57 (Psychosurgery)
Section 64B, 64C When medical treatment may be given to Community Patients.	**When treatment may be given to patients on CTO** • Relevant treatment may be given if: - Patient has capacity and consents to treatment; and - Requirements for second opinion certificate from an independent RMP are met. • Certificate from RMP not required: - During first month of CTO; or - If emergency treatment is required for patients lacking capacity for consent (pursuant to s.64G), or - If treatment is immediately necessary and patient has capacity and consents to treatment.
Section 64D Conditions to administer medical treatment to Community Patients that lack capacity to consent to treatment.	**When Community Patients lack capacity** • Before a patient on a CTO who lacks capacity may be given treatment, persons authorized to give treatment must ensure: - Reasonable steps are taken to establish whether patient lacks capacity to consent. - When giving treatment, person giving treatment must reasonably believe patient lacks capacity to consent to it. - There is no reason to believe patient objects to being given treatment, or if there is reason to believe patient objects it is not necessary to use force against the patient to give the treatment. - Person giving treatment is an Approved Clinician (**AC**) or treatment is given under direction of AC.
Section 64FA Required Actions when CTO Patient Withdraws Consent	**Withdrawal of consent** • Patients may withdraw their consent at any time. • If having given consent but before completion of treatment a patient loses capacity to consent to treatment, the patient shall be treated as if they have withdrawn their consent. • Where consent withdrawn or where patient loses capacity to consent to treatment, the remainder of treatment shall be considered a separate form of treatment and the conditions set forth for administering medical treatment to patients who lack capacity will then apply (sections 64D and 64F). • Treatment may be continued if AC considers discontinuance of treatment would cause serious suffering to the patient; subject to the conditions set forth for administering medical treatment to patients on a CTO under sections 64B, 64C, and 64E.

Table 4.3 - Consent to Treatment

UK MHA Reference and Summary	Key Principles Proposed for Bermuda MHA
Section 64G Emergency Treatment for patients lacking capacity.	**Emergency treatment** • Except for ECT, emergency treatment can be given by an AC (or under the direction of an AC) to a patient who lacks capacity to consent if the following conditions are met: - When giving treatment, AC reasonably believes patient lacks capacity to consent to treatment. - Treatment is immediately necessary. • If necessary to use force in order to give treatment: - The treatment must be needed to prevent harm to the patient - Force used must be proportionate response to likelihood of patent suffering harm and the seriousness of that harm. • Treatment is considered immediately necessary if it is needed to: - Save patients life; or - Prevent a serious deterioration in patient's condition and it is not irreversible; or - Alleviate serious suffering by the patient and it is not irreversible or hazardous; or - Prevent patient from behaving violently, being a danger to himself or to others where treatment represents the minimum interference necessary and is not irreversible or hazardous. • ECT may be given only if treatment is needed to: - Save patients life, or - Prevent a serious deterioration in patient's condition and it is not irreversible.
Section 64H Supplemental guidelines for certificates issued by a Registered Medical Professional	**Supplemental guidelines** • Where a certificate is required from an independent RMP: - Certificates should be in a form prescribed by Appropriate Authority - RMP must consult two other professionals concerned with patient's medical treatment ▪ At least one of which shall not be an RMP ▪ Neither of which shall be patients RC or person in charge of patient's treatment in question • Appropriate Authority may: - Require a report on treatment and patient's condition and such report shall be given by the person in charge of the treatment. - Give notice that a certificate, in certain circumstances, should be issued under a certain section of the Act versus another section of the Act when applicable. ▪ In such cases, treatment may be continued pending compliance with the relevant section if the person in charge of treatment considers discontinuance of treatment would cause serious suffering to the patient.
Section 64I Liability for Negligence	**Liability** • Person's civil liability for loss or damage, or criminal activity, resulting from negligence in doing anything authorized to be done under sections 64D, 64F, and 64G.
Section 64J Factors in determining whether patient objects to treatment	**Factors to consider when patient objects to treatment** • When determining if a patient objects to treatment, a person shall consider all the circumstances so far as they are reasonably ascertainable, including the patients: behavior, wishes, feelings, views, beliefs and values. • Circumstances from the past shall be considered only so far as still appropriate.

Please see the following Reference Documents for further details:

- Bermuda Mental Health Act 1968, section 15
- UK Mental Health Act 1983, sections 57 – 64
- UK Mental Health Act 1983, Code of Practice, chapters 24, 25

4.4 Mental Capacity

Background

4.4.1 Mental capacity is essential to a patient's ability to understand the nature, purpose and effects of treatment if they are to consent (or not) to treatment: whether the patient is voluntarily being treated, being treated in hospital under the MHA, or being treated in the community under a Community Treatment Order. An individual's ability to Consent to Treatment therefore is based on their Mental Capacity to do so.

4.4.2 The matter of Mental Capacity reaches far beyond the realm of mental health treatment, as evidenced by the UK Mental Capacity Act 2005. The UK MCA sets the minimum requirements in determining capacity and assisted decision making for health, care and welfare decisions. The UK MHA then places additional requirements on these general principles specific to treatment under the Act (e.g. ECT, psychosurgery etc). The Project Team is keenly aware of the need for the broader mental capacity framework. However, in consideration of timeframes and priorities it was deemed beyond the scope of Phase I. The broader issue of Mental Capacity will however be included in the Phase II review of the Act if not addressed before though other initiatives.

Issue

4.4.3 A patient cannot Consent to Treatment unless they have the Mental Capacity to do so. However, the Act currently does not address Mental Capacity. Therefore guidance, though legislative amendment is required for the following elements:

- Definition of a person who lacks capacity
- Criteria for determining whether a person is unable to make a decision about a matter and therefore lacks capacity in relation to that matter.
- Patient safeguards to ensure that decisions made or acts done on behalf of a patient that lacks capacity are made or done in the patient's best interests
- Safeguards to ensure practitioners (e.g. doctors, nurses and aides) are protected against liability for certain acts in connection with care or treatment of a patient who lacks capacity, provided the practitioner has complied with the provisions as outlined in the legislation.

4.4.4 Without adopting certain provisions related to Mental Capacity there can be no consideration given to adopting the amendments related to Consent to Treatment as recommended in this document.

Solution:

> ***Introduce provisions under the Act for determining Mental Capacity.***
>
> **Means:** Amend the Act to include (i) Provisions for Mental Capacity similar to those found in sections 1 - 6 and sections 28 and 44 of the UK MCA 2005 as outlined in Table 4.4. And (ii) Procedures to develop and revise a Code of Practice to guide practitioners in the day-to-day application of the Act similar to those found in section 42 of the UK MCA 2005 as outlined in Table 4.4.

4.4.5 Adopting the key principles of Mental Capacity from the UK legislation as outlined in Table 4 below will address the gaps noted above and provide the framework for determining mental capacity together with the necessary safeguards for both patients and practitioners.

4.4.6 The Project Team also recommends this amendment be promoted by the Ministry as a policy framework for the wider application of assessing mental capacity and assisted decision making in other areas of the community prior to more comprehensive legislative change.

4.4.7 Components of the UK MCA as presented in Table 4.4 are proposed to be included within Bermuda's legislation:

Table 4.4 - Mental Capacity

UK MCA Reference and Summary	Key Principles Proposed for Bermuda MHA
Part I, Section 1 Key Principles	**Key principles applying to decisions and actions taken** • A person: - is assumed to have capacity unless it is established they lack capacity - is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success - is not to be treated as unable to make a decision merely because they have made an unwise decision • Acts done or decisions made on behalf of a person who lacks capacity must be done or made in his/her best interests • Before an act is done, or a decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedoms of action.
Part I, Section 2 People who lack capacity	**Definition of a person who lacks capacity** • A person lacks capacity if at the particular time when a decision has to be made in relation to a particular matter he/she is unable to make a decision for themselves in relation to the matter because of an impairment or disturbance in the functioning of the brain or mind. • It does not matter if the impairment or disturbance is permanent or temporary. • A lack of capacity cannot be established by merely referencing: - Persons age or appearance - A condition, or an aspect of behavior, which might lead others to make unjustified assumptions about a person's capacity • Any question whether a person lacks capacity must be decided on the balance of probabilities • No power which a person, acting on behalf of one who lacks capacity, may exercise under provisions proposed herein may be exercisable in relation to a person under 18 years of age.
Part I, Section 3 Inability to make decisions	**Test for assessing whether a person is unable to make a decision about a matter, therefore lacking capacity in relation to that matter** • A person is unable to make a decision for themselves if the person is unable to: - Understand the information relevant to the decision - Retain that information - Use or weigh that information as part of the process of making the decision - Communicate their decision (whether by talking, sign language, or any other means) • A person is not to be regarded as unable to understand the information relevant to a decision if they are able to understand the explanation provided in a way that is appropriate to their circumstances (i.e. using simple language, visual aids, or other means) • The fact that a person is able to retain the information relevant for the decision for only a short period does not prevent them from being regarded as being able to make the decision. • The information relevant to a decision includes information about the reasonably foreseeable consequences of: - Deciding one way or another, or - Failing to make the decision

Table 4.4 - Mental Capacity

UK MCA Reference and Summary	Key Principles Proposed for Bermuda MHA
Part I, Section 4 Best Interests	**All steps and decisions taken for someone who lacks capacity must be taken in the person's best interests** • In determining what is in an individual's best interest, the person making the determination must not make it merely on the basis of the individual's: - Age and appearance, or - Condition of, or aspect of the individual's behavior, which might lead others to make unjustified assumptions what might be in their best interests • The person making the determination must: - Consider all the relevant circumstances - Consider whether it is likely that the individual will at some time have the capacity in relation to the matter in question, and - Consider if it appears likely that the individual will have capacity, when that would likely be. • So far as reasonably practicable, the person making the determination must: - Permit and encourage the person to participate or improve their ability to participate in the decision or, as fully as possible, in any act done for him - Consider the individual's past and present wishes and feelings - Consider the individual's beliefs and values that would be likely to influence the decision if they had capacity, and - Consider any other factors the person would likely to consider if they were able to do so • Where the determination relates to life-sustaining treatment the person making the decision must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by the desire to bring about their death • If practicable and appropriate to consult them, the person making the determination must take into account the views of: - anyone named by the person as someone to be consulted on the matter(s) of that kind, - anyone engaged in caring for the person or interested in their welfare as to what would be in the individuals best interests.
Part I, Section 5 Acts in connection with care or treatment	**Statutory protection against liability for certain acts done in connection with the care and treatment of another person** • If a person performs an act in connection with the care or treatment of another person, the act is one to which this section applies provided: - Before the act is performed, the person performing the act has taken reasonable steps to establish whether the individual on which the act is to be performed, lacks capacity in relation to the particular matter in question, and - When performing the act, the person performing the act reasonably believes: ▪ That the individual on which the act is being performed lacks capacity in relation to the matter, and ▪ That performing the act will be in the best interest of the individual on which the act is to be done. • The person performing the act will not incur any liability in relation to the act if the individual on which the act is being performed: - Had had capacity to consent in relation to the matter, and - Had consented to the person performing the act, to do so. • The person performing the act is not protected under this section from civil liability for loss or damage, or any criminal liability, resulting from his/her negligence in performing the act.

Table 4.4 - Mental Capacity

UK MCA Reference and Summary	Key Principles Proposed for Bermuda MHA
Part I, Section 6 Limitations to Acts described in Section 5	**Limitations to acts protected under Section 5** • If a person performs an act that is intended to restrain another person, the following conditions must be satisfied if the person performing the act is to be protected against liability under Section 5 above: - The person performing the act reasonably believes that it is necessary to do the act in order to prevent harm to the person on which the act is being performed - The act is a proportionate response to: ▪ The likelihood of the person on which the act is being performed, suffering harm, and ▪ The seriousness of that harm. • A person is considered to restrain another person if he: - Uses, or threatens to use, force to secure the performance of an act that the person on which the act is being performed resists, or - Restricts the person on which the act is being performed liberty of movement, whether or not the person on which the act is being performed, resists. • Nothing in this section stops a person from: - Providing life-sustaining treatment, or - Doing any such act which the person performing the act reasonably believes to be necessary to prevent a serious deterioration in the person on which the act is being performed, condition.
Part I, Sections 27 – 29 Excluded Decisions – Application of Capacity Framework	**Nothing in this mental capacity section authorizes anyone:** • To give a patient medical treatment for mental disorder, or • To consent to a patient's being given medical treatment for mental disorder if at the time when it is proposed to treat the patient, his/her treatment is regulated under the proposed "Consent to Treatment" amendments to the Bermuda Mental Health Act. **Application** The Mental Capacity framework proposed herein shall be restricted for use in relation to patients detained under the Mental Health Act only as proposed in this consultation paper.
Part I, Section 42 Code of Practice *(modified to incorporate all Mental Health treatment)*	**Development of a Code of Practice** • For the guidance of - Registered medical practitioners and other professionals responsible for the care and treatment of patients suffering from mental disorder, - Persons assessing whether a person has capacity in relation to any matter, - For the guidance of persons acting in connection with the care or treatment of another person • With respect to such other matters concerned with provisions contained in the MHA or the proposed amendments to the MHA and/or as considered appropriate. • Responsibility for the preparation or revision of the whole or any part of the Code, may be delegated so far as considered expedient. • Before issuing or amending the Code, a draft of the Code or amendment shall be published in a manner that is considered appropriate, inviting representations to be made by stakeholders relevant to the Mental Health Act and such representations taken into consideration. • Any Code of Practice issued may be used as evidence in court or tribunal hearings where it appears to a court or tribunal that a provision of the Code of a failure to comply with a Code is relevant to a question arising in proceedings before the court or tribunal.

Table 4.4 - Mental Capacity

UK MCA Reference and Summary	Key Principles Proposed for Bermuda MHA
Part I, Section 44 ill-Treatment or Neglect	**Offence to ill-treat or willfully neglect a person lacking capacity** • A person who is responsible for the care of an individual who lacks (or who the person responsible for the care reasonably believes to lack) capacity - will be guilty of an offence if he/she ill-treats or willfully neglects the individual who lacks capacity. • A person guilty of an offence under this section will be liable for - Punishment on conviction on indictment: imprisonment for 2 years; - Punishment on summary conviction: imprisonment for 6 months or a fine of $720 or both such imprisonment and fine.

Please see the following Reference Documents for further details:

- UK Mental Capacity Act 2005, sections 1-6, 28, 42, 44
- UK Mental Capacity Act 2005, Code of Practice, chapters 1 – 5

5.0 Consultation Requirements

5.1 The Steering Committee welcomes the views of key stakeholders as to the recommendations proposed in this consultation paper. Comments as to policy changes recommended are welcome but not required (i.e. Nearest Relative). Comments as to legislative changes are requested to ensure input from all interested parties is taken into consideration as part of this consultation process.

5.2 Stakeholders are asked to address the following questions for each recommendation included in this document:

a. Does your organization agree with the recommendation as outlined?
b. What concerns (if any) does your organization have with the recommendation outlined?
c. What changes does your organization suggest be made to the recommendations that will address the concerns you have noted in question b?

5.3 Any questions or comments included in responses should be clearly cross-referenced to the relevant paragraph number or table and section number as outlined in this Consultation Paper.

5.4 Stakeholders are asked to submit responses to the Ministry of Health no later than 4:00pm local time on 28th February 2018 via one of the following methods:

a. Online at https://goo.gl/forms/gpWJs4Pbg1GM7Btl1
b. In electronic format (i.e. in Word or PDF format) via email to: moh@gov.bm
Please include "MHA Consultation Submission_<insert organization name>" in the subject line of your email.
c. In written form via post to:

Ministry of Health
25 Church Street
Hamilton, HM 12
Attention: MHA Consultation Submissions

5.5 Please include your name and organization you are representing with your submission.

5.6 <u>Please do not send consultation submissions to the Minister.</u>

5.7 Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the Public Access to Information Act (PATI).

Annex 1: Policy Development and Consultation Process

The Steering Committee and Project Team established to develop this initiative are as follows:

Steering Committee:

- Permanent Secretary Jennifer Attride-Stirling, Ministry of Health (Chair)
- Lt. Col. Edward Lamb, Commissioner, Department of Corrections
- Mr. Rod Attride-Stirling, Chairman, Mental Health Review Tribunal
- Mrs. Gina Hurst-Maybury, Director, Department of Court Services
- Mrs. Kelly Madeiros, Coordinator, Mental Health Treatment Court
- Dr. Guy Fowle, Director, Bermuda Mental Health Foundation
- Mr. Scott Pearman, Chief Operating Officer, Bermuda Hospitals Board
- Dr. Chantelle Simmons, Chief of Psychiatry, Bermuda Hospitals Board

Project Team:

- Dr. Chantelle Simmons, Chief of Psychiatry, Bermuda Hospitals Board (Chair)
- Dr. Anna Neilson-Williams, Deputy Chief of Psychiatry, Bermuda Hospitals Board
- Dr. Seb Henagulph, Consultant Forensic Psychiatrist, Bermuda Hospitals Board
- Mr. Glenn Caisey, Director, Mental Health Services, Bermuda Hospitals Board
- Mr. Jamie Campbell, Consultant, Modernization Project Office, Bermuda Hospitals Board
- Mrs. Kelly Madeiros, Coordinator, Mental Health Treatment Court
- Mr. Saul Dismont, Attorney, Marshall Diel & Myers
- Ms. Sarah D'Alessio, Policy Analyst, Ministry of Health
- Dr. Alick Bush, Clinical Psychologist, Bermuda Hospitals Board

The Project Team researched the issues identified and with input from the Steering Committee, made recommendations for certain policy and legislative changes required to address the major gaps that exist in Bermuda's Mental Health Act. This consultation paper includes recommendations for both changes to policy and changes to legislation that are considered urgent in nature.

Stakeholder feedback on the proposed set of changes is requested to ensure no concerns have been overlooked in the solutions proposed. Upon receipt of comments from stakeholders a revised version of this document incorporating responses received will be prepared and submitted for legislative drafting.

Reference Documents

Document	Link
Bermuda Mental Health Act 1968	https://goo.gl/95Bfpk
UK Mental Health Act 1983	https://goo.gl/mfjVsn
UK Mental Capacity Act 2005	https://goo.gl/k9SsXJ
UK Mental Health Act 1983 – Code of Practice	https://goo.gl/UuL812
UK Mental Capacity Act – Code of Practice	https://goo.gl/97PK2K