GOVERNMENT OF BERMUDA

**Ministry of Health**

Bermuda Mental Health Act 1968:

# CODE OF PRACTICE

GOVERNMENT OF BERMUDA

**Ministry of Health**

| | |
|---|---|
| **Contact information for Code of Practice:** | BHB Mental Health Act Administrator<br>Telephone: 236 3770<br>Email: MHA@bhb.bm |
| **Complaints regarding non-compliance with the Code of Practice** | Complaints must first be directed to the **unit/ department manager of the relevant** service provider.<br><br>BHB Complaints:<br>Patient Relations Manager at 239 1425, or<br><br>feedback@bhb.bm or<br><br>**Patient Relations Manager,**<br>Quality and Risk Department<br>Bermuda Hospitals Board<br>PO Box 1023<br>Hamilton, Bermuda HMDX |
| **Overview:** | To provide guidance to medical practitioners, staff of Bermuda Hospitals Board and mental health professionals on how they should carry out their responsibilities under the Mental Health Act ('the Act') when providing treatment and care for persons suffering from mental disorder, in accordance with the 2019 Amendments to the Mental Health Act 1968.<br><br>A series of Accessible Pamphlets is being developed for patients, nearest relatives and carers. These will set out details about people's rights, how to obtain further information, and how to make a complaint if it is felt that the Mental Health Act and the Code are not being implemented as they should be. The Code will be updated over time and updates will be published. |
| **Effective date:** | **18 January 2021** |
| **Version:** | **1.0** |

**Cover art:** *Mo'Betta Blues* by Lynwood Richardson, 2019

**Bermuda Mental Health Act 1968: Code of Practice v1.0**

Prepared and published by Bermuda Hospitals Board on behalf of the Ministry of Health, Government of Bermuda

# TABLE OF CONTENTS

## PRELIMINARY


| CHAPTER | | PAGE |
|---|---|---|
| **1** | Ministerial Foreword | 5 |
| **2** | Executive summary | 6 |
| **3** | Introduction | 8 |


## USING THE ACT


| CHAPTER | | PAGE |
|---|---|---|
| **4** | Guiding principles | 9 |
| | Respect for patients' past and present wishes and feelings | 9 |
| | Respect for diversity including, in particular, diversity of religion, culture and sexual orientation | 9 |
| | Minimizing restrictions on liberty | 10 |
| | Involvement of patients in planning, developing and delivering care and treatment appropriate to them | 10 |
| | Avoidance of unlawful discrimination | 11 |
| | Effectiveness of treatment | 11 |
| | Views of carers and other interested parties | 11 |
| | Patient wellbeing and safety | 12 |
| | Public safety | 12 |
| **5** | Mental disorder definition | 13 |


## PROTECTING PATIENTS' RIGHTS AND AUTONOMY


| CHAPTER | | PAGE |
|---|---|---|
| **6** | Information for patients, nearest relatives, carers and others | 18 |
| **7** | Privacy, safety and dignity | 24 |
| **8** | Confidentiality and information sharing | 27 |
| **9** | Mental Capacity | 29 |


## ASSESSMENT AND ADMISSION TO HOSPITAL


| CHAPTER | | PAGE |
|---|---|---|
| **10** | Applications for detention in hospital | 34 |
| **11** | Nearest Relative | 38 |
| **12** | Treatment under the Act | 44 |

## LEAVING HOSPITAL


| CHAPTER | | PAGE |
| --- | --- | --- |
| **13** | Community Treatment Orders | 48 |


## PROFESSIONAL RESPONSIBILITIES


| CHAPTER | | PAGE |
| --- | --- | --- |
| **14** | Appointment, selection and utilization of SOADs | 57 |
| **15** | Appointment and qualifications of Mental Welfare Officers | 58 |


## APPENDICES


| | | |
| --- | --- | --- |
| **I** | Key words and phrases used in this Code | 60 |
| **II** | Summary of Mental Health Act Detention Sections | 68 |
| **III** | Medical requirements for civil detention (s13, 9, 10) | 70 |
| **IV** | Appeals and Statutory Referrals to MHRT | 71 |
| **V** | Forms to be used when implementing the Mental Health Act | 73 |

Government of Bermuda
Ministry of Health

## MESSAGE FROM THE MINISTER, THE HON. KIM N. WILSON, JP, MP

It gives me great pleasure to offer an introductory foreword for this inaugural Mental Health Code of Practice.

The Ministry of Health is committed to ensuring that good quality care is provided to all patients subject to the Mental Health Act 1968. Accordingly, the 2019 Amendment to the Act recognized advances in mental health treatment and detention based on human rights, case law, and clinical best practice. This includes additional legal safeguards, the option for community based treatment and the introduction of a Code of Practice.

The Code includes nine guiding principles to outline and help ensure the rights of patients and best practices are upheld. The first published Code provides a framework for professionals including:

- A set of principles to be followed when implementing the Mental Health Act
- Guidance for professionals assessing a patient's capacity
- Introduction of Community Treatment Orders to provide a greater focus on care and treatment in the community rather than in hospital
- Introduction of Second Opinion Appointed Doctors, and clarification on the role of Mental Welfare Officers.

The Code must be considered and implemented by healthcare professionals and is applicable to both patients in hospital and those in the community that fall under the Act, their families, carers and advocates. The Code outlines how care and treatment must be: a means to promote recovery, of the shortest duration necessary, the least restrictive as possible and serves to keep the patient and others safe. Overall, it provides guidance to help make sure anyone treated under the Mental Health Act gets the right care, treatment and support.

The Code will be updated periodically as needed. My thanks for the support and work of the professionals under the Bermuda Hospitals Board for the development of this Code of Practice.

Sincerely,

*The Hon. Kim N. Wilson, JP, MP*
**Minister of Health**

Continental Building, 25 Church Street, Hamilton HM 12, Bermuda
P.O. Box HM 380, Hamilton HM BX, Bermuda • Telephone: 441.278.4900, Ext. 4901 • Facsimilie: 441.292.2622

# CHAPTER 2: EXECUTIVE SUMMARY

This Code of Practice provides guidance to medical practitioners, staff of Bermuda Hospitals Board and mental health professionals on how they should carry out their responsibilities under the Mental Health Act ('the Act') when providing treatment and care for persons suffering from mental disorder.

This Code also helps patients and their families to understand what they can expect from health professionals who are assisting with their loved ones' treatment.

### Using the Act: Chapters 4 – 5

These chapters explain the nine overarching principles that underpin the Act, provide guidance on the definition of mental disorder, and highlight equality and human rights considerations in relation to the Act. The nine overarching principles should be considered when making all decisions in relation to care, support or treatment provided under the Act:

- *Respect for the patients' past and present wishes and feelings*
- *Respect for diversity including, in particular, diversity of religion, culture and sexual orientation*
- *Minimising restrictions on liberty*
- *Involvement of patients in planning, developing and delivering care and treatment appropriate to them*
- *Avoidance of unlawful discrimination*
- *Effectiveness of treatment*
- *Views of carers and other interested parties*
- *Patient wellbeing and safety*
- *Public safety*

### Protecting patients' rights and autonomy: Chapters 6 – 9

Empowerment and involvement of patients and carers, and dignity and respect are principles underpinning the Act. These chapters address issues related to empowering patients, protecting their rights and autonomy, and ensuring they are treated with dignity and respect. Guidance is given on the assessment of capacity and a patient's ability to make a decision. It sets out the factors that should be considered in order to work out the best interests of a person who lacks the capacity to make a particular informed decision.

### Assessment and admission to hospital: Chapters 10 – 11

To assist with understanding the legal framework that governs a patient's assessment and admission to hospital, in this group of chapters, guidance is provided about applications for detention under the Act.

It may be necessary to remove people from public places or from private premises and guidance is given about powers to do that and the circumstances under which a patient may need to be detained for assessment.

### Care, support and treatment in hospital: Chapter 12

This chapter addresses issues related to the care and treatment of patients. Guidance is given on medical treatment for mental disorder under the Act, including on certain treatments which are subject to special rules and procedures under the Act.

## Leaving hospital: Chapter 13

Patients may leave hospital under a variety of circumstances, including being fully discharged, on short-term leave or to receive care and treatment in the community under a Community Treatment Order (CTO).

CTOs may be used to allow suitable patients to leave hospital and to be treated in the community and this chapter's guidance is about the use of CTOs and patients for whom they are suitable.

## Professional responsibilities: Chapters 14 – 15

These chapters provide guidance on responsibilities in relation to Second Opinion Approved Doctors (SOAD) and Mental Welfare Officers (MWO).

# **CHAPTER 3:** INTRODUCTION

3.1 The Mental Health Amendment Act 2019 (Amendment Act), which amends the Mental Health Act 1968 (Principal Act), provides for a Code of Practice (Code). Generally, the Code upholds the shift in focus from institutional mental health care to community based treatment. The purpose of this Code is to describe what is expected of all registered medical practitioners and other health professionals when treating and caring for patients with a mental disorder including a) facilitating community treatment orders b) obtaining consent to treatment and c) assessing capacity to consent to treatment.

3.2 This Code is aligned with the requirements set out in section 78A of the Amendment Act. It includes parameters for appointing Mental Welfare Officers (MWO), including their training and experience; and how to use Second Opinion Approved Doctors (SOADs).

3.3 Where the Code refers to 'carers', it means a family member, friend or others who may be involved in the care of the patient. Where the term 'nearest relative' is used, it means the nearest relative as defined in the Act (section 8), rather than the family member (including co-habiting families) who may be closest to the individual. Nominated next of kin is also different from the nearest relative as defined in the Act.

3.4 It is expected that all decisions made under the Act be informed by the statement of principles outlined in section 78A of the Amendment Act. These principles balance consideration of the views of patients, carers and other interested parties with patient and public safety. They also include respect for the patients' wishes including involving patients in decision-making and minimizing restrictions on their liberty. There are also principles related to avoiding discrimination and respecting diversity.

3.5 The Amendment Act provides for the Minister (or his delegate) to review and amend the Code as needed. Such amendments will be published.

# CHAPTER 4: GUIDING PRINCIPLES

## Why read this chapter?

There are nine overarching principles which should always be considered when making decisions in relation to mental health care, support and treatment provided under the Act. This chapter provides an explanation of these principles and highlights what to consider when making decisions under the Act. Although all are of equal importance, the weight given to each principle in reaching a particular decision will depend on the context, the mental health status of the patient, and the nature of the decision being made. The nine overarching principles are:

- *Respect for the patients' past and present wishes and feelings*
- *Respect for diversity including, in particular, diversity of religion, culture and sexual orientation*
- *Minimising restrictions on liberty*
- *Involvement of patients in planning, developing and delivering care and treatment appropriate to them*
- *Avoidance of unlawful discrimination*
- *Effectiveness of treatment*
- *Views of carers and other interested parties*
- *Patient wellbeing and safety*
- *Public safety*

When using the Act and guiding principles, all decisions must be lawful and informed by good professional practice and best practices. All principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle during decision-making should consider the circumstances, mental health status of the patient, and nature of each particular decision. Providers and professionals providing care under the Act should document, and justify, any decision to depart from the Code or a particular guiding principle. The principles are detailed as follows:

### Respect for the patients' past and present wishes and feelings

4.1 Patients' views, past and present wishes and feelings (whether expressed at the time or in advance), should be considered as far as they are reasonably ascertainable. Patients should be encouraged and supported to develop advance statements of wishes and feeling and express their views about future care and treatment when they are well.

4.2 Patients' choices and views should be fully recorded and comprehensively documented in their medical record. Where a decision in the care plan is contrary to the wishes of the patient or others, the reasons for this should be transparent, fully explained and documented.

### Respect for diversity including, in particular, diversity of religion, culture and sexual orientation

4.3 The diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, and culture must be considered when making decisions under the Act.

4.4 Patients and carers should be treated with respect and dignity. The rights and dignity of patients and their carers should be respected while also ensuring their safety and that of others.

## Minimising Restrictions on Liberty

4.5 Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. International human rights law determines that no person shall be deprived of their personal liberty unless this is authorized by law. When such a deprivation of liberty is required as a consequence of a person's mental disorder, the Mental Health Act provides the legal framework for this.

4.6 If detention is necessary, it should be used for the shortest time necessary in the least restrictive setting available. Further, any restrictions should be minimal to safely provide the care or treatment required, ensuring to uphold patients' rights and freedom of action. This will promote recovery and enable the patient to maintain contact with family, friends, and their community.

4.7 Care plans for detained patients should focus on maximizing recovery and ending detention as soon as possible.

4.8 Restrictions that apply to all patients in a particular setting (blanket or global restrictions) should be avoided. There may be settings where there will be restrictions on all patients that are necessary for their safety or for that of others. Any such restrictions should have a clear justification for the group or ward to which they apply. Blanket restrictions should never be for the convenience of the provider. Any such restrictions should be agreed as required, documented with the reasons for such restrictions and subjected to the organisation's governance procedures.

4.9 Health professionals and other relevant agencies should work together to prevent mental health crises and, where possible, reduce the use of detention through prevention and early intervention by making available a range of services that are accessible, responsive and as high quality as other health emergency services.

## Involvement of Patients in Planning, Developing and Delivering Care and Treatment Appropriate to Them

4.10 Patients should be given the opportunity to be involved in planning, developing and reviewing their own care and treatment to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. Wherever possible, care plans should be produced in consultation with the patient.

4.11 Patients should be enabled to participate in decision-making as far as they are capable of doing so. Consideration should be given to what assistance or support a patient may need to participate in decision-making and any such assistance or support should be provided, to ensure maximum involvement possible. This includes being given sufficient information about their care and treatment in a format that is easy for them to understand.

4.12 In situations where it is considered that a person does not have the capacity to consent to the treatment that is being proposed or risk to self/others is judged to outweigh a capacitous refusal of treatment, the principles set out in paragraphs 9.1 to 9.15 of the Code should be followed.

4.13 Patients should be informed of the support that is available to them, including carers, advocacy agencies and any policies or legal parameters related to their care.

## Avoidance of Unlawful Discrimination

4.14 People making decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, culture, religion or belief, sex and sexual orientation. There must be no discrimination.

4.15 Providers, including their staff, should give equal priority to mental health as they do to physical health conditions.

## Effectiveness of Treatment

4.16 Treatment should address an individual patient's needs, taking account of their circumstances and preferences where appropriate. Where this is available, care, support and treatment given under the Act should be given in accordance with any up-to-date guidance and/or current best practice from professional bodies.

4.17 Professionals should deliver a range of treatments that focus on positive clinical and personal outcomes, where appropriate.

4.18 Providers and professionals should consider the broad range of interventions and services needed to promote recovery, not only in hospital, but also after a patient leaves hospital including maintaining relationships, housing, and opportunities for meaningful daytime therapeutic activity and employment opportunities.

4.19 Physical healthcare needs should be assessed and addressed including promoting healthy living and taking steps to reduce any potential side effects associated with treatment. This includes making an appropriate referral for care to address these needs.

4.20 Providers and other relevant organisations should ensure that their staff have sufficient skills, information and knowledge about the Act and provision of services to support all their patients. There should be clear mechanisms for accessing specialist support for those with additional needs.

## Views of Carers and Other Interested Parties

4.21 Patients should be encouraged and supported in involving carers (unless there are particular reasons to the contrary).

4.22 The views of families, carers and others, if appropriate, should be fully considered when making decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reason(s) for this and document their reasoning.

## Patient Wellbeing and Safety

4.23 Patients should be offered treatment and care in environments that are safe for them, staff and any visitors; and are supportive and therapeutic.

4.24 It is an offence for a person who has care, control or custody to ill-treat or wilfully neglect a person who has a mental disorder or a person they believe lacks mental capacity (section 65).

4.25 It is an offence for a member of staff who is employed by the hospital or a care home or group home to have unlawful sexual intercourse with a patient that has a mental disorder who is receiving treatment or outpatient treatment, or to have such intercourse on the premises of the hospital or home. It is also an offence for a person to have unlawful sexual intercourse with a patient with a mental disorder in their custody or care, under the Act (section 66).

## Public safety

4.26 Professionals performing functions under the Act should respect the rights and dignity of patients and their carers, whilst also ensuring their safety and that of others.

4.27 When deciding whether detention is necessary for the protection of other people, professionals will always consider the risk to other people arising from the person's mental disorder, the likelihood that harm will result and the severity of any potential harm.

4.28 Professionals should note that it is not always possible to differentiate risk of harm to the patient from the risk of harm to others.

# **CHAPTER 5:** MENTAL DISORDER DEFINITION

## Why read this chapter?

- This chapter provides guidance on the definition of mental disorder for the purposes of the Act. Mental disorder is defined in the Act as 'any disorder or disability of the mind'. Examples of clinically recognised disorders or disabilities are given and it is made clear that difference should not be confused with disorder.
- Guidance is provided on dependence on alcohol or drugs, intellectual disabilities and autistic spectrum disorders.
- The Act applies to personality disorders in exactly the same way as it applies to mental illness and other mental disorders.

## Definition of Mental disorder

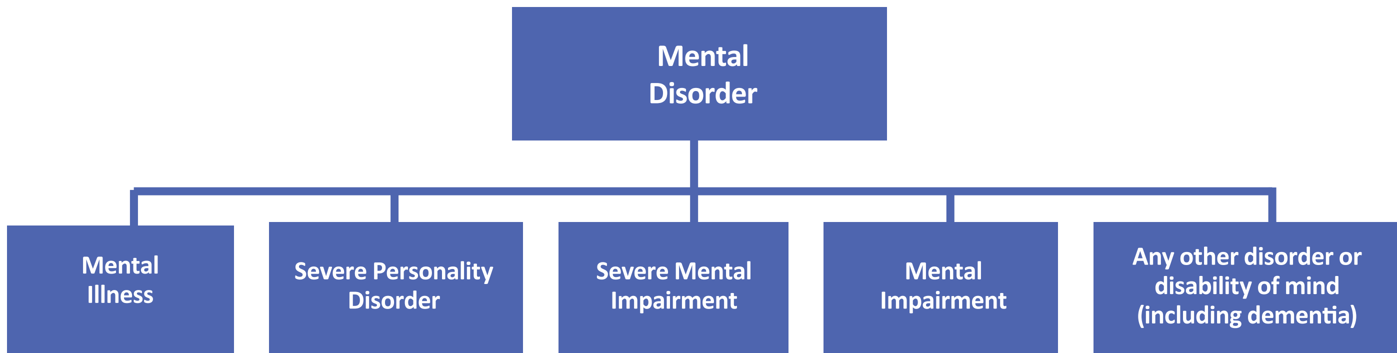
5.1 The Mental Health Act applies only to those who suffer from mental disorder. Historically, since medieval times, the law has distinguished between lunacy, idiocy and moral insanity. In the English 1959 Act these divisions were further codified as explained below.

The importance of specifying mental disorder as criteria for detention stems from the European Convention on Human Rights which only permits the "lawful detention…of persons of unsound mind" in accordance with a procedure prescribed by law. Lawful detention requires "the existence of a specific condition of mental ill-health" established "on the basis of objective medical expertise."

5.2 Mental Disorder is defined in the Act as: *"mental disorder" means mental illness, arrested or incomplete development of mind, severe personality disorder, and any other disorder or disability of mind; and "mentally disordered" shall be construed accordingly;*

- Mental illness is not statutorily defined, but taken to refer to those illnesses described in either the DSM-5 or ICD10/11. For purposes of detention under the MHA this is typically the severe mental illnesses such as schizophrenia, bipolar disorder and severe depression.
- *"arrested or incomplete development of mind"* refers to what was historically called *"idiocy"* and is today called intellectual disability
- *"severe personality disorder"* was historically called *"moral insanity"* and more recently called psychopathic disorder and, as defined in the Act, refers to a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) *which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;*
- *"mental impairment"* was previously called subnormality and, as defined in the Act, means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and *is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned* and *"mentally impaired"* shall be construed accordingly;
- *"severe mental impairment"* was previously called severe subnormality and, as defined in the Act, means a means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and *is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned* and *"severely mentally impaired"* shall be construed accordingly;

This means that there are 5 broad legal categories of mental disorder.




5.3 According to the Act, a person can be admitted to hospital for any of the 5 forms of mental disorder for purposes of assessment (under section 13 or 9) but in order to be detained for treatment (for example under section 10) or maintained in the community under section 20 or a Community Treatment Order, the person must be shown to be suffering from at least one of the first four categories of mental disorder.

This is also important as both medical practitioners making medical recommendations for treatment under section 10 must agree on at least one of the categories of mental disorder being present.

A further distinction in the Act is to differentiate between so-called "major" forms of mental disorder (mental illness and severe mental impairment) and "minor" forms – (severe personality disorder and mental impairment).

5.4 Examples of clinically recognised conditions that could fall within this definition are given in Table 1.

Table 1: Clinically recognised conditions that could fall within the Act's definition of mental disorder include (the list is not exhaustive):

| CATEGORY | EXAMPLE |
|---|---|
| Schizophrenia and other psychotic disorders | • Schizophrenia<br>• Schizoaffective disorder<br>• Delusional disorder |
| Mood disorders | • Depressive disorders<br>• Bipolar disorder |
| Disruptive behaviour or dissocial disorders | • Oppositional defiant disorder<br>• Conduct-dissocial disorder |
| Feeding or eating disorders | • Anorexia Nervosa<br>• Bulimia Nervosa |
| Anxiety or fear-related disorders | • Generalised anxiety disorder<br>• Social anxiety disorder<br>• Post-traumatic stress disorder |

| | |
|---|---|
| Neurodevelopmental disorders | • Autism Spectrum Disorder<br>• Attention Deficit Hyperactivity Disorder<br>• Disorders of intellectual development |
| Neurocognitive disorders | • Dementia<br>• Delirium |
| Dissociative disorders | • Dissociative amnesia<br>• Dissociative identity disorder |
| Personality disorders and related traits | • Dissociality<br>• Borderline pattern |
| Obsessive-compulsive or related disorders | • Obsessive-compulsive disorder<br>• Body dysmorphic disorder<br>• Hoarding disorder |
| Disorders specifically associated with stress | • Post-traumatic stress disorder<br>• Prolonged grief disorder<br>• Adjustment disorder |

5.5 The fact that someone has a mental disorder is never sufficient grounds for any compulsory measure to be taken under the Act. Compulsory measures are permitted only where specific criteria about the potential consequences of a person's mental disorder are met. There are many forms of mental disorder that are unlikely to call for compulsory measures.

5.6 Care must always be taken to avoid diagnosing, or failing to diagnose, mental disorder based on preconceptions about people or failure to appreciate cultural and social differences. What may be indicative of mental disorder in one person, given their background and individual circumstances may be nothing of the sort in another person.

5.7 Difference should not be confused with disorder. No one may be considered to be mentally disordered solely because of their political, religious or cultural beliefs, values or opinions, unless there are proper clinical grounds to believe that they are the symptoms or manifestations of a disability or disorder of the mind. The same is true of a person's involvement, or likely involvement, in illegal, anti-social or 'immoral' behaviour. Beliefs, behaviours or actions which do not result from a disorder or disability of the mind are not a basis for compulsory measures under the Act, even if they appear unusual or cause other people alarm, distress or danger.

## Patients with dementia

5.8 Individuals who are presenting signs and symptoms of dementia as well as those with a confirmed diagnosis of dementia can fall within the Act's definition of mental disorder (but see 5.2 and 5.3 above for clarity about which sections of the MHA can be applied). Dementia can pose particular challenges, and understanding of the condition is essential to delivery of quality care. People with dementia may present and behave in very different ways from those with other kinds of mental disorder. It is important that such behaviours are understood properly if the Act is to be used appropriately. Effective communication is key to supporting people to understand the assessment process, e.g. giving people time to answer questions and using non-verbal aids where appropriate.

5.9 Some people with dementia may display challenging behaviour because they are distressed, confused or in pain. The use of sedation or antipsychotic medication may not be appropriate in these circumstances and alternative intervention or treatment could be deemed more appropriate.

## Exclusions

**Dependence on alcohol and drugs**

5.10 Alcohol or drug dependency is not considered a disorder or disability of the mind for the purposes of the definition of mental disorder in the Act.

5.11 There are no grounds under the Act for detaining a person in hospital (or using other compulsory measures) based on alcohol or drug dependence alone. Drugs for these purposes may be taken to include solvents and similar substances with a psychoactive effect.

5.12 Alcohol or drug dependence may be accompanied by, or associated with, a mental disorder that does fall within the Act's definition. If the relevant criteria are met, it is therefore possible, for example, to detain people who are suffering from mental disorder, even though they are also dependent on alcohol or drugs. This is true even if the mental disorder in question results from the person's alcohol or drug dependence.

5.13 The Act does not exclude other disorders or disabilities of the mind related to the use of alcohol or drugs. These disorders – e.g. withdrawal state with delirium or associated psychotic disorder, acute intoxication, organic mental disorders associated with prolonged abuse of drugs or alcohol – remain mental disorders for the purposes of the Act.

5.14 Medical treatment for mental disorder under the Act (including treatment with consent) can include measures to address alcohol or drug dependence if that is an appropriate part of treating the mental disorder, which is the primary focus of the treatment.

**Intellectual (learning) disabilities and autistic spectrum disorders**

5.15 Within the Act, an application for admission for treatment may be made in respect of a patient of any age suffering from a severe mental impairment, or in the case of a patient under the age of 18 years, suffering from a mental impairment, providing they also meet the other requirements for admission. These are defined as:

- "Mental impairment" means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned, and "mentally impaired" shall be construed accordingly.
- "Severe mental impairment" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "severely mentally impaired" shall be construed accordingly.

The term “mental impairment” has widely been replaced in clinical practice by the terms “learning disability” or “intellectual disability”. Both terms have a similar meaning. An intellectual disability is described as:

- Significantly reduced ability to understand new or complex information, to learn new skills, and
- Reduced ability to cope independently, which starts before adulthood with lasting effects on development

5.16 Someone with an intellectual (learning) disability and no other form of mental disorder may not be detained for treatment or made subject to a community treatment order (CTO) unless it is necessary, in the interests of the patient’s health or safety or for the protection of other persons, that the person should be detained. Professionals should record their reasons for concluding that it is necessary to detain them in accordance with the conditions set out in paragraphs 10.7 and 10.8, and why it relates to the person’s intellectual (learning) disability and is not attributable to others factors such as an unmet physical health, social or emotional need.

5.17 It is possible for someone with an autistic spectrum disorder to meet the criteria for compulsory measures under the Act without having any other form of mental disorder, even if it is not associated with abnormally aggressive or seriously irresponsible behaviour. While experience suggests that this is likely to be necessary only very rarely, the possibility should never automatically be discounted.

# CHAPTER 6: INFORMATION FOR PATIENTS, RELATIVES, CARERS AND OTHERS

## Why read this chapter?

- This chapter gives guidance on the information that must be given to patients, and their nearest relatives. It also gives guidance on communication with patients, their families and carers, and other people.
- Effective communication is essential in ensuring appropriate care and respect for patients' rights, and those responsible for caring for patients should identify any communication difficulties and seek to address them. The Act requires the detaining authority to take steps to ensure that patients who are detained or are the subject of a Community Treatment Order (CTO) understand important information about how the Act applies to them.

## Communication with patients

6.1 Professionals will communicate effectively, ensuring appropriate care and respect for patients' rights. The language used will be clear and unambiguous and people giving information will check that the information that has been communicated has been understood.

6.2 Everything possible should be done to overcome barriers to effective communication, which may be caused by any of a number of reasons. A patient's cultural background may also be different from that of the person speaking to them. Information should be explained in a way that patients can understand and in a format that is appropriate to their condition. Information should be additionally communicated in writing as appropriate.

6.3 Where an interpreter is needed, every effort should be made to identify an interpreter who is appropriate to the patient, given the patient's sex, religion or belief, dialect, cultural background and age. Interpreters need to be skilled and experienced in medical or health-related interpreting. Using the patient's relatives and friends as intermediaries or interpreters is not good practice, and should only be used as an exception and with the patient's permission. Interpreters (both professional and non-professional) must respect the confidentiality of any personal information they learn about the patient through their involvement.

6.4 Wherever possible, patients should be engaged in the processes of reaching decisions, which affect their care and treatment under the Act. Consultation with patients involves helping them to understand the information relevant to decisions, their own role and the roles of others who are involved in making decisions.

6.5 Ideally, decisions should be agreed with the patient. Where a decision is made that is contrary to the patient's wishes, that decision and the authority for it should be explained to the patient using a form of communication that the patient understands. Carers and advocates should be involved where the patient wishes or if the patient lacks capacity to understand.

## Information for detained patients and patients on Community Treatment Orders (CTOs)

6.6 The Act requires responsible medical officers to take steps to ensure that patients who are detained in hospital under the Act, or who are subject to a CTO, understand important information about how the Act applies to them. This must be done as soon as practicable after the start of the patient's detention or the CTO. This information must be given to patients subject to a CTO ('community patients') who are recalled to hospital at the time they are being recalled.

6.7 Information must be given to the patient both orally and in writing. This may need to be in an accessible format and in a language the patient understands. Those providing information to patients should ensure that all relevant information is communicated in a way that the patient understands.

6.8 It would not be sufficient to repeat what is already written in an information leaflet as a way of providing information orally.

## Information about detention and CTOs

6.9 Patients must be informed:

- of the provisions of the Act under which they are detained or subject to a CTO and the effect of those provisions
- of the rights (if any) of their nearest relative to discharge them (and what can happen if their responsible medical officer does not agree with that decision)
- for community patients, of the effect of the CTO, including the conditions which they are required to keep and the circumstances in which their responsible medical officer may recall them to hospital

6.10 As part of this, they should be told:

- the reasons for their detention or CTO
- the maximum length of the current period of detention or CTO
- that their detention or CTO may be ended at any time if it is no longer required or the criteria for it are no longer met
- that they will not automatically be discharged when the current period of detention or CTO ends
- that their detention or CTO will not automatically be renewed or extended when the current period of detention or CTO ends
- the reasons for being recalled
- for patients subject to a CTO, the reasons for the revocation of a CTO

6.11 Patients should also be told the essential legal and factual grounds for their detention or CTO. For the patient to be able to adequately and effectively challenge the grounds for their detention or their CTO, should they wish, they should be given the full facts rather than simply the broad reasons. This should be done promptly and clearly. They should be told they may seek legal advice, and assisted to do so if required.

6.12 A copy of the detention or CTO documentation should be made available to the patient as soon as practicable and as a priority, unless the responsible medical officer is of the opinion (based on the advice of the authors of the documents) that the information disclosed would adversely affect the health or wellbeing of the patient or others. It may be necessary to remove any personal information about third parties.

6.13 Where the section of the Act under which the patient is being detained changes, they must be provided with the above information to reflect the new situation. The same applies where a detained patient becomes subject to a CTO.

## Information about recall to hospital whilst on CTO

6.14 Where a patient is to be recalled to hospital (see paragraphs 13.26 – 13.42), the responsible medical officer should give or arrange for the patient to be given oral reasons for the decision before the recall. The patient may nominate another person who they wish to be notified of the decision.

## Information about consent to treatment

6.15 Patients must be told what the Act says about treatment for their mental disorder. In particular they must be told:

- the circumstances (if any) in which they can be treated without their consent – and the circumstances in which they have the right to refuse treatment
- the role of second opinion appointed doctors (SOADs) and the circumstances in which they may be involved
- where relevant, the rules on electro-convulsive therapy (ECT) and medication administered as part of ECT (see paragraphs 12.20 – 12.25).

## Information about seeking a review of detention or CTOs

6.16 Patients must be informed of their rights to be considered for discharge, particularly:

- of the power of the responsible medical officer to discharge them
- of their right to ask the responsible medical officer to discharge them
- that the responsible medical officer must consider discharging them when their detention is renewed or their CTO is extended
- of their rights to apply to the Tribunal including:
  - of the rights (if any) of their nearest relative to apply to the Tribunal on their behalf
  - about the role of the Tribunal
  - how to apply to the Tribunal

6.17 Responsible medical officers should ensure that patients are offered assistance to request a hearing or make an application to the Tribunal, and that the applications are transmitted to the Tribunal without delay. They should also be advised:

- how to contact a suitably qualified legal representative (and should be given assistance to do so if required)
- how to contact any other organisation which may be able to help them make an application to the Tribunal

6.18 It is particularly important that patients are well informed and supported to make an application to the Tribunal if a) they are on a CTO, b) do not otherwise have regular contact with their nearest relative or people who could help them make an application, and/or c) lack capacity.

6.19 Patients whose CTOs are revoked and conditionally discharged patients recalled to hospital, should be told that their cases will be referred automatically to the Tribunal.

## Information about withholding of correspondence

6.20 Detained patients must be told that their letters for posting may be withheld if the person to whom it is addressed asks the responsible medical officer to do so. On occasions it may be necessary to restrict patients' access to electronic communications including social media. In such circumstances the basis of this decision will be clearly documented in the medical record.

## Keeping patients informed of their rights

6.21 Those with responsibility for patient care should ensure that patients are reminded from time to time of their rights and the effects of the Act. It may be necessary to give the same information on a number of different occasions or in different formats and to check regularly that the patient has fully understood it. Information given to a patient who is unwell may need to be repeated when their condition has improved.

6.22 An explanation of the patient's rights should be considered in particular where:

- the patient is considering applying to the Tribunal, or when the patient becomes eligible again to apply to the Tribunal
- the patient requests the responsible medical officer to consider discharging them, or such a request is declined
- the rules in the Act about their treatment change (e.g. because three months have passed since they were first given medication, or because they have regained capacity to consent to treatment)
- any significant change in their treatment is being considered
- there is to be a multi-disciplinary case review (or its equivalent)
- renewal of their detention, or extension of their CTO is being considered
- a decision is taken to renew their detention or to extend their CTO
- a decision is taken to recall a community patient or revoke a CTO
- a decision is taken to recall a conditionally discharged patient to hospital

6.23 When a detained patient or a community patient is discharged or the authority for their detention or the CTO expires, this fact should be made clear to them. The patient should be given an explanation of what happens next including any after-care or other services that are to be provided.

## Information for nearest relatives

6.24 It is understood that relatives are important to patient recovery. As such, health professionals will take such steps as are practicable to give the patient's nearest relative a copy of any information given to the patient in writing, unless the patient requests otherwise. The information should be given to the nearest relative when the information is given to the patient, or within a reasonable time afterwards.

6.25 When a patient detained under the Act or subject to a CTO is given information, they should be told that the written information will also be supplied to their nearest relative, so that they can discuss their views

about sharing this information and following this discussion, raise any concerns or object to the sharing of some or all of this information. There should be discussion with the patient at the earliest possible time as to what information they are happy to share and what they would like to be kept private.

6.26 The nearest relative must be told of the patient's discharge from detention or CTO (where practicable), unless either the patient or the nearest relative has requested that information about discharge should not be given. This includes discharge from detention onto a CTO. If practicable, the information should be given at least seven days in advance of the discharge.

6.27 The duty to inform nearest relatives is not absolute. In almost all cases, information is not to be shared if the patient objects.

6.28 Occasionally there will be cases where these duties do not apply because disclosing information about the patient to the nearest relative cannot be considered practicable, because it would have a detrimental impact on the patient that is disproportionate to any advantage to be gained from informing the nearest relative.

6.29 Before disclosing information to nearest relatives without a patient's consent, the person concerned must consider whether the disclosure would be likely to:

- put the patient at risk of physical harm or financial or other exploitation
- cause the patient emotional distress or lead to a deterioration in their mental health
- have any other detrimental effect on their health or wellbeing and, if so, whether the advantages to the patient and the public interest of the disclosure outweigh the disadvantages to the patient, in the light of all the circumstances of the case

## Involvement of Carers

6.30 Carers are key partners with health and care services in providing care, especially for relatives and friends who have mental disorders. In many instances, especially when a patient is not in hospital, the patient's carers and wider family will provide more care and support than health and social care professionals. It is important for professionals to identify all individuals who provide care and support for patients, to ensure that health and care services assess those carers' needs and, where relevant, provide support to meet those needs.

6.31 Unless there are good reasons to the contrary, patients should be encouraged to agree to their carers being involved in decisions under the Act and to them being kept informed.

6.32 In order to ensure that carers can, where appropriate, participate fully in decision making, it is important that they have access to:

- practical and emotional help and support to assist them to participate
- timely access to comprehensive, up-to-date and accurate information

6.33 Even if carers cannot be given detailed information about the patient's case, where appropriate, they should be offered general information in an appropriate form, which may help them understand the nature of mental disorder, the way it is treated, and the operation of the Act.

6.34 If carers request that the information they provide is kept confidential, this should be respected and recorded in the patient's medical record. A carer should be asked to consent to such information being disclosed. Where a carer refuses to consent, professionals should discuss with the carer the benefits of sharing information in terms of patient care and how their concerns could be addressed.

## Information about complaints or if the Act is not being applied appropriately

6.35 A patient and persons supporting them (e.g. a patient's nearest relative, family, carer, advocate or legal representative), especially a patient lacking capacity, must be supported to make a complaint if they think the safeguards of the Act are not being appropriately applied or they have concerns about the care and treatment being provided.

6.36 Professionals should be aware that it could be particularly difficult for patients and those supporting them to take forward complaints due to their mental health and fear that this may affect the quality of care and support they receive. All efforts must be made to support patients (especially those lacking capacity) and those supporting them to make complaints without any negative impact on the quality of care and support provided.

6.37 Professionals should advise about complaints policies and procedures. Patients and those supporting them (including nearest relatives, family, carers and advocates) must be given information about how to make a complaint about those involved in their treatment. The information must be in formats that these individuals can understand.

6.38 Information about how to make a complaint should be displayed within the hospital and accessible to the public online.

# CHAPTER 7: PRIVACY, SAFETY AND DIGNITY

## Why read this chapter?

- This chapter deals with privacy, safety and dignity in hospitals where patients are detained under the Act, including access to telephones and other mobile computing devices, access to the internet, and the use of searches.
- Sleeping and bathroom areas should be segregated to protect the needs of patients of different genders and transgender patients. The nature of engagement with patients and of therapeutic environments and the structure and quality of life on a ward are important in encouraging patients to remain in the ward and minimising a culture of containment.
- The chapter also includes guidance on conducting personal and other searches, enhanced security, physical security and blanket locked door policies.

## Respect for privacy

7.1 Professionals should make conscious efforts to respect the privacy and dignity of patients as far as possible, while maintaining safety, including enabling a patient to wash and dress in private, and to send and receive mail, including in electronic formats, without restriction. Respecting patients' privacy encompasses the circumstances in which patients may meet or communicate with people of their choosing in private, including in their own rooms, and the protection of their private property.

## Blanket restrictions

7.2 Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each patient should be considered and documented in the patient's medical record.

7.3 Restrictions should never be introduced or applied in order to punish or humiliate, but only ever as a proportionate and measured response to an individually identified risk; they should be applied for no longer than can be shown to be necessary.

7.4 Blanket restrictions include restrictions concerning: access to the outside world, access to the internet, access to (or banning) mobile phones and chargers, incoming or outgoing (electronic) mail, visiting hours, access to money or the ability to make personal purchases, or taking part in preferred activities. Such practices have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient's human rights.

7.5 No form of blanket restriction should be implemented unless expressly authorised by the detaining authority  because of the organisation's policy and subject to local accountability and governance arrangements.

## Blanket locked door policy

7.6 A blanket locked door policy which affects all patients in a hospital or on a ward could, depending on its implementation, amount to a restriction of liberty.

7.7 The patient should be told who they can speak to if they wish to leave and must be able to leave at any time they wish to, unless they are being detained under the Act.

7.8 Hospitals should not lock patients in clinical areas simply because of inadequate staffing levels. Local policies for locking clinical areas should be clearly displayed and explained to each patient on admission.

7.9 The safety of voluntary patients, who would be at risk of harm if they wandered out of a clinical environment at will, should be ensured by adequate staffing levels, positive therapeutic engagement and good observation, not simply by locking the doors of the unit or ward.

7.10 Services should consider how to reduce the negative psychological and behavioural effects of having locked doors, whether or not patients are formally detained.

## Private property

7.11 Hospitals should ensure that patients' personal property can be stored safely. The option should be available for patients to store items of monetary value in a safe area. Items which may pose a risk to the patient or to others, e.g. razors, may need to be stored in a central area. Information about arrangements for storage should be easily accessible to patients on the ward.

7.12 Hospitals should compile an inventory of what has been allowed to be kept on the ward and what has been stored and give a copy to the patient. The inventory should be updated when necessary. Patients should always be able to access their private property on request if it is safe to do so.

## Separate facilities for men and women

7.13 Hospitals must ensure the personal safety of women and other potentially vulnerable groups of people who may be at risk of a loss of privacy due to the behavior of other patients. It is important that staff are aware of the potential for increased risk of sexual, physical and other potential forms of abuse within a ward environment, and of the risk of trauma for women who have had prior experience of abuse. Where possible, vulnerable patients should be cared for in areas that are physically separate from patients who may potentially intimidate them. At all times, staff should closely monitor all patients to ensure that no one comes to harm whilst they are an inpatient.

7.14 Consideration should be given to the particular needs of transgender patients.

## Conducting personal and other searches

7.15 The consent of the person should always be sought before a personal search of them or a search of their possessions is attempted. If consent is given, the search should be carried out with regard to ensuring the maximum dignity and privacy of the person. Undertaking a personal search in a public area will only be justified in exceptional circumstances.

7.16 A person being searched or whose possessions are the subject of a search should be kept informed of what is happening and why. If they do not understand or are not fluent in English, the services of an interpreter should be sought, if practicable. The specific needs of people with impaired hearing or a learning (intellectual) disability should be considered.

7.17 A personal search should be carried out by a member of the same sex, unless necessity dictates otherwise. The search should be carried out in a way that maintains the person's privacy and dignity and respects issues of gender, culture and faith. It is always advisable to have another member of the hospital staff present during a search, especially if it is not possible to conduct a same-sex search.

7.18 A comprehensive record of every search, including the reasons for it and details of any consequent risk assessment, should be made.

7.19 Staff involved in undertaking searches should receive appropriate instruction and refresher training.

7.20 In certain circumstances, it may be necessary to search a detained patient or their possessions without their consent.

7.21 If a detained patient refuses consent or lacks capacity to decide whether or not to consent to the search, their responsible medical officer (or, failing that, another senior clinician with knowledge of the patient's case) should be contacted without delay in the first instance, if practicable, so that any clinical objection to searching by force may be raised. The patient should be kept separated and under close observation, while being informed of what is happening and why, in terms appropriate to their understanding. This is particularly important for individuals who may lack capacity to decide whether or not to consent to the search. Searches should not be delayed if there is reason to think that the person is in possession of anything that may pose an immediate risk to their own safety or that of anyone else.

7.22 If a search is considered necessary, despite the patient's objections, and there is no clinical objection to one being conducted, the search should be carried out. If force has to be used, it should be the minimum necessary.

7.23 Where a patient's belongings are removed during a search, the patient should be told why they have been removed, given a receipt for them, told where the items will be stored, and when they will be returned.

# CHAPTER 8: CONFIDENTIALITY AND INFORMATION SHARING

## Why read this chapter?

- This chapter deals with issues about confidentiality and information sharing which arise in connection with the Act. All users of the Act will need to be cognisant of the Personal Information Protection Act (PIPA) and to be aware of the additional guidance in relation to patients who are detained under the Act.

- The law on confidentiality is the same for patients subject to the Act as it is for any other patient, except where the Act says otherwise. Under the Act, there are some situations where confidential information about a patient is legally authorised to be disclosed, even if the patient does not consent. Guidance is given on the sharing of information by professionals and agencies to manage serious risks which certain patients pose to others.

## Disclosure of confidential patient information for the purposes of the Act

8.1 Information sharing between professionals can contribute to and support the care and treatment of patients, and help to protect people from harm. Patients must be consulted about what information it may be helpful to share with these services and when. Professionals should be clear about how the sharing of such information could benefit the patient, or help to prevent serious harm to others and whether there are any potential negative consequences.

8.2 Sharing information with carers and other people with a valid interest in the care and wellbeing of the patient can contribute to and support their care and treatment. Where patients have capacity to agree and are willing to do so, carers and other people with a valid interest should be given information about the patient's progress. This will help them form and offer views about the patient's care and provide effective care and support to the patient, especially if the individual is a community patient, or on leave from hospital.

8.3 The Act creates a number of situations where confidential information about patients is legally authorised to be disclosed, even if the patient does not consent. These include:

- reports to the Tribunal when a patient's case is to be considered
- the right for SOADs to access records relating to patients

8.4 Where the Act allows steps to be taken in relation to patients without their consent, it is implicit that confidential patient information may be disclosed only to the extent that it is necessary to take those steps. For example, confidential patient information may be shared to the extent that it is necessary for:

- medical treatment which may be given without a patient's consent under the Act
- safely and securely transporting a patient to hospital (or anywhere else) under the Act
- finding and returning a patient who has absconded from legal custody or who is absent without leave
- transferring responsibility for a patient who is subject to the Act from one set of people to another (eg where a detained patient is to be transferred from one hospital to another, or where responsibility for a patient is to be transferred between jurisdictions)

## Limitations on sharing information with carers

8.5 Simply asking for information from carers, relatives, friends or other people about a patient without that patient's consent need not involve any breach of confidentiality, provided the person requesting the information does not reveal any personal confidential information about the patient which the carer, relative, friend or other person being asked would not legitimately know.

8.6 Carers cannot be told a patient's particular diagnosis or be given any other confidential personal information about the patient unless the patient consents or there is another basis on which to disclose it in accordance with the law. Carers should always be offered information which may help them understand the nature of mental disorder generally, the ways it is treated and the operation of the Act. Carers have a responsibility to ensure that any information that they are provided regarding their relative, is also preserved and protected.

8.7 Carers, relatives, friends and other people have a right to expect that any personal information about themselves, or any information about the patient which they pass on to professionals in confidence, will be treated as confidential. Unless there is an overriding reason that makes it necessary and there is legal authority to do so, information they provide about patients should not be repeated to patients in a way that might reveal its source, unless the carer, relative, friend or other person was made aware that disclosure could happen and had not objected to it.

## Sharing information to manage risk

8.8 Although information may be disclosed only in accordance with the law, professionals and agencies may need to share information to manage any serious risks which certain patients pose to others.

8.9 Where the issue is the management of the risk of serious harm, the judgement required is normally a balance between the public interest in disclosure, including the need to prevent harm to others, and both the rights of the individual concerned and the public interest in maintaining trust in a confidential service.

8.10 Whether there is an overriding public interest in disclosing confidential patient information may vary according to the type of information. Even in cases where there is no overriding public interest in disclosing detailed clinical information about a patient's state of health, there may, nonetheless, be an overriding public interest in sharing more limited information about the patient's current, and past status under the Act, if that will help ensure properly informed risk management by the relevant authorities, families and carers.

8.11 Situations in which disclosure is required by law, e.g. mandatory reporting under the Senior Abuse Register Act 2008 or Children Act 1998, this should be carried out in accordance with the appropriate legislation.

## Recording disclosure without consent

8.12 Any decision to disclose confidential information about patients should be fully documented. The relevant facts should be recorded, with the reasons for the decision and the identity of all those involved in the decision-making. Reasons should be given by reference to the grounds on which the disclosure is to be justified.

# CHAPTER 9: MENTAL CAPACITY

## Why read this chapter?

- A sound understanding and application of the common law principles of mental capacity and of consent are essential to enable decision-makers to fulfil their responsibilities under the Act and to safeguard their patients' rights. The Act applies to professionals and lay people who are involved in the assessment, treatment and care of persons suffering (or believed to be suffering) from mental disorder.
- This chapter describes how an individual's capacity to consent should be assessed, and how care and support should be delivered to individuals who lack the capacity to make their own decisions.
- In the absence of specific Bermuda legislation that addresses capacity and consent, this chapter is based upon the common law test of what constitutes capacity. It is reflective of the rules applicable to all individuals, whether suffering mental disorder or not.

## Determining capacity

9.1 In relation to a patient, "consent" is the voluntary permission of a patient to be given to a proposed treatment where sufficient information has been given to the patient. This should set out the purpose of the treatment, its nature, likely effects and risks to that treatment, including the likelihood of its success and any alternatives to it (Section 48Z(a)). Individuals should be empowered to make their own decisions where possible and where they cannot, protections of individual rights are given for those who lack capacity. Where an individual lacks capacity to make a specific decision at a particular time, the capacity framework that is set out in paragraphs 9.2 to 9.15 provides guidance for others to act and make that decision on their behalf, in their best interests, and with deference to their care and/or treatment.

9.2 When determining matters of capacity, there are five guiding principles, as follows:

i. A person must be assumed to have capacity unless it is established that they lack capacity
ii. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success
iii. A person is not to be treated as unable to make a decision merely because they make an unwise decision
iv. An act done, or decision made, on behalf of a person who lacks capacity, must be done, or made, in their best interests
v. Before the act is done, or the decision is made, consideration must be given as to whether the purpose of the act or the decision can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

9.3 It is important for professionals to be aware that individuals with a mental disorder, including those liable to be detained under the Act, do not necessarily lack capacity. The assumption should always be that a patient subject to the Act has capacity, unless it is established otherwise in accordance with the capacity framework as detailed below.

## Assessing Capacity

9.4 Anyone who assesses someone's capacity to make a decision should use the two stage test of capacity:

**Stage 1:** Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? This can be a temporary or a permanent impairment or disturbance.

**Stage 2:** If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Examples of an impairment or disturbance in the functioning of the mind or brain may include:

- Conditions associated with some forms of mental illness
- Dementia
- Significant learning (intellectual) disabilities
- The long-term effects of brain damage
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- The effects of medication that may have a sedating or hypnotic effect e.g. pain relief, following anaesthesia
- Delirium
- Concussion following a head injury
- The symptoms of alcohol or drug use

## Assessing ability to make a decision

9.5 In order to assess the second part of the two stage test of a person's capacity to make the decision in question, the following four criteria need to be achieved. If the person is unable to meet one or a combination of any of these 4 criteria in relation to the specific decision in question, it is deemed that they are unable to make the decision:

- Does the person have a general understanding of what decision they need to make and why they need to make it? And
- Does the person have a general understanding of the likely consequences of making or not making the decision? And
- Is the person able to understand, retain, use and weigh up the information relevant to the decision? And
- Can the person communicate their decision (by talking, using sign language or any other means)?

9.6 As capacity relates to specific matters and can change over time, capacity should be reassessed as appropriate over time and in respect of specific treatment decisions. Health professionals should note that the test of capacity should be used whenever assessing a patient's capacity to consent for the purposes of the Act (including, for instance, under Part IIIB of the Act).

The person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times.

It is up to the professional responsible for a person's treatment to make sure that capacity has been assessed. For some complex decisions it may be necessary to carry out a more formal assessment (e.g. by a psychiatrist, psychologist, speech therapist, occupational therapist or social worker). However, the final decision about a person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity- not the professional who is there to advise.

9.7 Health professionals should ensure that where a capacity assessment is undertaken, this is recorded in the individual's care and treatment record. As well as the outcome of the test, the following should be recorded:

- the specific decision for which capacity was assessed
- the salient points that the individual needs to understand and comprehend and the information that was presented to the individual in relation to the decision
- the steps taken to promote the individual's ability to decide themselves. How the information was given in the most effective way to communicate with the individual
- how the diagnostic test was assessed, and how the assessor reached their conclusions
- how the functional test was undertaken, and how the assessor reached their decision

9.8 The five guiding principles of the capacity framework form a vital part of developing a patient's care plan and should be integral to this process.

9.9 Professionals should seek to involve those who lack capacity in decisions about their care as much as they would involve those who have capacity. Care plans should be developed in collaboration with the patient as much as possible. Where professionals and patients disagree over elements of the care plan the emphasis should be on discussion and compromise where possible. Restrictions (including restraint) of liberty should only be considered when absolutely necessary and when all appropriate efforts at building consensus and agreement have failed.

9.10 Care planning, including planning for discharge, must adhere to the steps for determining what is in the person's best interests as detailed below. This ensures participation by the person and consideration of their wishes, feelings, beliefs and values and consultation with specified others (eg carers, attorneys and people nominated by the person) about the person's best interests.

## What is meant by 'Best Interests'?

9.11 In considering the best interests of a particular patient at a particular time, decision-makers should look at the person's welfare in the widest sense, not just medical, but social and psychological. They should consider the nature of the treatment in question, what it involves and its prospect of success. They should consider what the outcome of that treatment for the patient is likely to be. They should try to put themselves in the place of the individual patient and ask what their attitude is, or would be likely to be.

A professional trying to work out the best interests of a person who lacks capacity to make a particular decision ('lacks capacity') should weigh up all these factors in order to work out what is in the person's best interests:

- Encourage participation of the patient in decision making
- Identify all relevant circumstances related to the decision
- Find out the person's views including past and present wishes and feelings
- Avoid discrimination and making assumptions
- Assess whether the person might regain capacity and whether the decision can wait
- Determine if the decision concerns life-sustaining treatment, and ensure that they are not motivated by a desire to bring about the person's death
- Consult others who have an interest in the patient's welfare, while protecting confidentiality
- Avoid restricting the person's rights

## Providing care and treatment to someone who lacks capacity:

9.12 Very often some acts need to be done to and for people who lack capacity including everyday tasks of caring (e.g. helping someone to wash) to life-changing events (e.g. medical treatment or arranging for placement in a care home). Actions that may need to be done for a person in their best interests who lacks capacity may include:

**Personal Care:**
- Helping with washing dressing or personal hygiene; helping with eating and drinking or with mobility
- Helping someone to access education, social or leisure activities
- Doing the shopping with the person's money; going into their home to drop off shopping or see if they are alright
- Arranging household services (e.g. arranging repairs or maintenance)
- Helping someone to move house

**Healthcare and treatment:**
- Carrying out diagnostic examinations and tests
- Providing professional medical, dental and similar treatment
- Giving medication
- Taking someone to hospital for assessment or treatment
- Providing nursing care
- Carrying out any other necessary medical procedures (e.g. taking a blood sample), or therapies such as physiotherapy or chiropody
- Providing care in an emergency

9.13 It is necessary for the person who is carrying out these acts to:

- Have reasonable belief that the person being cared for lacks capacity to give permission for the actions, and
- The action must be in the person's best interests and must follow the guidance set out in this section.

9.14 In considering the use of restraint when providing care for someone who lacks capacity, professionals should carefully take into account the need to respect an individual's liberty and autonomy. In addition to needing to be in the best interests of the person who lacks capacity in respect of the relevant decision, acts of restraint will only be permitted if:

- the person taking action reasonably believes that restraint is necessary to prevent harm to the person who lacks capacity, and
- the amount or type of restraint used and the amount of time it lasts is a proportionate response to the likelihood and seriousness of that harm.

Professionals should be guided by the relevant organisational policy

9.15 It is important to note that if a potential restriction of liberty is identified, the first step should always be to review the care plan to see if a less restrictive approach could be taken that would prevent that deprivation of liberty from arising. The Mental Health Act provides the framework for the lawful restriction of the freedom of people who meet the criteria set out in the Act. In addition, common law can be used to authorise a restriction of liberty, but it cannot be used to deprive a person of their liberty. A deprivation of liberty is likely to be occurring if:

- the person is under continuous supervision and control; and
- is not free to leave; and
- the person lacks the capacity to consent to these arrangements

Just because a person is not overtly objecting to the restrictions that are being imposed upon them does not mean that they are not being deprived of their liberty.

# CHAPTER 10: APPLICATIONS FOR DETENTION IN HOSPITAL

## Why read this chapter?

- This chapter gives guidance on making applications for detention in hospital under Part II of the Act.
- An application for detention may only be made where the grounds in either section 9 or section 10 of the Act are met. An application for detention may be made by a Mental Welfare Officer (MWO) or the patient's nearest relative, with understanding of the criteria for detention and their responsibilities under the Act.
- Other forms of detention can also be made under sections 7 (3), 13, 14, 71 and 72.

## Grounds for making an application for detention

10.1 An application for detention may only be made where the grounds in either section 9 or section 10 of the Act are met (see below).

## Criteria for applications

10.2 A person can be detained for assessment under section 9 only if both the following criteria apply:
- the person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period
- the person ought to be so detained in the interests of their own health or safety or with a view to the protection of others

10.3 A person can be detained for treatment under section 10 only if both the following criteria apply:
- the person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital
- it is necessary for the health or safety of the person or for the protection of other persons that they should receive such treatment and it cannot be provided unless the patient is detained under this section

10.4 The criteria require consideration of both the nature and degree of a patient's mental disorder. Nature refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient's previous response to receiving treatment for the disorder. Degree refers to the current manifestation of the patient's disorder.

10.5 Before it is decided that admission to hospital is necessary, consideration must be given to whether there are alternative means of providing the care and treatment which the patient requires. This includes consideration of whether there might be other effective forms of care or treatment which the patient would be willing to accept.

10.6 In all cases, consideration should be given to:
- the patient's wishes and view of their own needs
- the patient's age and physical health
- any past wishes or feelings expressed by the patient

- the patient's cultural background
- the patient's social and family circumstances
- the impact that any future deterioration or lack of improvement in the patient's condition would have on their children, other relatives or carers, especially those living with the patient, including an assessment of their ability and willingness to cope
- the effect on the patient, and those close to the patient, of a decision to admit or not to admit under the Act

## The health or safety of the patient

10.7 Factors to be considered in deciding whether patients should be detained for their own health or safety include:

- the evidence suggesting that patients are at risk of:
    - suicide
    - self-harm, self-neglect or being unable to look after their own health or safety
    - jeopardizing their own health or safety accidentally, recklessly or unintentionally
- any evidence suggesting that the patient's mental health will deteriorate if they do not receive treatment, including the views of the patient or carers, relatives or close friends (especially those living with the patient) about the likely course of the disorder
- consideration of both the significance and the immediacy of the risk
- the patient's own skills and experience in managing their condition
- the patient's capacity to consent to or refuse admission and treatment
- whether the patient objects to treatment for mental disorder – or is likely to
- the reliability of such evidence, including what is known of the history of the patient's mental disorder and the possibility of their condition improving
- the potential benefits of treatment, which should be weighed against any adverse effects that being detained might have on the patient's wellbeing
- whether other methods of managing the risk are available

## Factors to consider – protection of others

10.8 In considering whether detention is necessary for the protection of other people, the factors to consider are the nature of the risk to other people arising from the patient's mental disorder, the likelihood that harm will result and the severity of any potential harm, taking into account:

- that it is not always possible to differentiate risk of harm to the patient from the risk of harm to others
- the reliability of the available evidence, including any relevant details of the patient's clinical history and past behaviour, such as contact with other agencies and (where relevant) criminal convictions and cautions
- the willingness and ability of those who live with the patient and those who provide care and support to the patient to cope with and manage the risk
- whether other methods of managing the risk are available
- harm to other people including psychological as well as physical harm

## Alternatives to detention under the Act

10.9 In deciding whether it is necessary to detain patients, professionals must always consider the alternative ways of providing the treatment or care they need. Professionals should always consider whether there are less restrictive alternatives to detention under the Act, which may include voluntary admission to hospital of a patient based on that person's consent.

10.10 In considering whether it is necessary for the person to be detained under the Act, professionals must consider whether the person has capacity to consent to or refuse admission and treatment. This should be assessed in accordance with the Guidelines in chapter 9 which makes clear that a person must be assumed to have capacity unless it is established that they do not.

10.11 Professionals must consider available alternatives, having regard to all the relevant circumstances, to identify the least restrictive way of best achieving the proposed assessment or treatment. This will include considering what is in the person's best interests (if the person lacks capacity, this will be determined in accordance with Chapter 9).

## Patients with capacity to give or to refuse consent to admission

10.12 When a patient needs to be in hospital, voluntary admission is usually appropriate when a patient who has the capacity to give or to refuse consent is consenting to admission.

10.13 Compulsory admission should, in particular, be considered where a patient's current mental state, together with reliable evidence of past experience, indicates a strong likelihood that they will have a change of mind about voluntary admission, either before or after they are admitted, with a resulting risk to their health or safety or to the safety of other people.

10.14 The threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent).

## Use of Section 9 or Section 10 of the Act

10.15 An application for detention can be made under either section 9 or section 10 of the Act.

10.16 Section 9 should generally be used if:

- the full extent of the nature and degree of a patient's condition is unclear
- there is a need to carry out an initial in-patient assessment in order to formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis following admission, or
- there is a need to carry out a new in-patient assessment in order to re-formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis.

10.17 Section 10 should generally be used if:

- the patient is already detained under section 9 (detention under section 9 cannot be renewed by a new section 9 application), or
- the nature and current degree of the patient's mental disorder, the essential elements of the treatment plan to be followed and the likelihood of the patient accepting treatment as a voluntary patient are already sufficiently established to make it unnecessary to undertake a new assessment under section 9.

10.18 The rationale for decisions to use section 9 or section 10 should be clearly recorded.

## The assessment process

10.19 An application for detention may be made by a Mental Welfare Officer (MWO) or the patient's nearest relative (for information on the nearest relative, see below). An MWO is usually a more appropriate applicant than a patient's nearest relative, 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.

10.20 An application for detention must be supported by two medical recommendations provided by medical practitioners, at least one of whom should be approved under the provisions of section 12 of the Act, typically a consultant psychiatrist. The medical practitioners shall have personally examined the patient either together, or at an interval of not more than seven days. A section 12 medical practitioner is one who is approved by the Board as having special experience in the diagnosis or treatment of mental disorder.

10.21 The objective of the assessment is to determine whether the criteria for detention are met and, if so, whether an application for detention should be made.

10.22 Because a proper assessment cannot be done without considering alternative means of providing care and treatment, MWO's and medical practitioners should, as far as possible in the circumstances, identify and liaise with services which may potentially be able to provide alternatives to admission to hospital.

# CHAPTER 11: ROLE OF THE NEAREST RELATIVE

## Why read this chapter?

- This chapter gives guidance on the identification, appointment and displacement of nearest relatives under the Act. The 'nearest relative' for the purposes of the Act may not be the same person as the patient's 'next of kin'. This chapter gives guidance on what to do if there is no nearest relative and displacement of nearest relatives and appointment of acting nearest relative by the Magistrates' court.

11.1 Section 8 of the Act defines 'relative' and 'nearest relative' for the purposes of the Act. It is important to remember that the nearest relative for the purposes of the Act may not be the same person as the patient's 'next of kin'. The identity of the nearest relative may change with the passage of time – e.g. if the patient enters into a marriage. The nearest relative may be the patient's carer and it is important that they are recognised, particularly as they may have the most relevant information to share with professionals with regard to the patient's care and interests. If the nearest relative is not the carer, professionals should also involve the carer.

The Act includes additional provisions to identify the nearest relative of a child or young person. For example:

- If the child or young person is subject to a care order (or interim care order) under the Children Act 1998, the Director of Child and Family Services (or designated person) will be the nearest relative, save for where the young person is married, in which case their spouse will be the nearest relative (section 28 of the Act)
- Unmarried fathers will only be treated as the child or young person's 'father' for the purpose of section 28 of the Act if they have 'parental responsibility' as defined under section 4 of the Children Act 1998.

11.2 Patients subject to special restrictions under part III of the Act do not have nearest relatives (as defined by the Act).

11.3 Where a Mental Welfare Officer discovers, when assessing a patient for possible detention under the Act (or at any other time), that the patient appears to have no nearest relative, the MWO should advise the patient that an application can be made to the Magistrates' court for the appointment of a person to act as their nearest relative. Such an application can be made by any relative of the patient, any other person with whom the person is residing (or if the patient is then an inpatient in a hospital, was last residing before they were admitted), or by an MWO.

## Meaning of relative in the Act [Section 8(1), (6) and (7)]

11.4 "Relative" is defined for the purposes of Part II of the Act as anyone who is a patient's:

- husband, wife
- son or daughter
- father or mother
- brother or sister
- grandparent
- grandchild
- uncle or aunt
- nephew or niece

11.5 This includes relationships both of the "whole blood" and the "half-blood" (i.e. with, or through, half-siblings).

11.6 It also includes relationships established through adoption (e.g. adoptive parent and child, adoptive aunt and nephew), but not step-relationships.

11.7 It does not include the relationship of a father and illegitimate child (and any relationship established through such a relationship, e.g. between uncle and niece) unless the father has parental responsibility for the child within the meaning of section 4 of the Children Act 1998.

11.8 "Husband" and "wife" include people living with a patient as if they were a husband or wife, provided they have done so for at least six months (or, when the patient is currently a hospital in-patient, they had lived together for at least six months before the patient's admission to hospital).

11.9 "Relative" also includes people who are not otherwise relatives but who are living ("ordinarily residing") with a patient and have done so for at least five years (or, when the patient is currently a hospital in-patient, had lived with the patient for at least five years before the patient's admission to hospital).

## Identification of the nearest relative [section 8(3) to (5)]

11.10 The general rule is that the nearest relative is the person who comes first in the list of relatives described above (with people who are only relatives because they have lived with the patient for at least five years coming at the bottom of that list).

11.11 Men and women take equal priority – so, for example, sons and daughters come in the same place in the list.

11.12 Where two or more people come in the same place in the list, the elder or eldest takes precedence (e.g. the elder parent or eldest sibling).

11.13 However, there are several exceptions to the general rule:

- a relative who lives with or cares for the patient (or, if the patient is now a hospital in-patient, did so until the patient's admission to hospital) takes precedence over other relatives
- a relative of the whole blood (e.g. a full brother or sister) takes precedence over one of the half-blood (e.g. a half-brother or half-sister) within any category of relatives (regardless of age)
- a husband or wife (or someone treated as such under the Act) who is permanently separated from the patient (whether by agreement or a court order) is not eligible to be the nearest relative
- a husband or wife (or someone treated as such under the Act) who has deserted, or been deserted by, the patient is also not eligible to be the nearest relative (broadly speaking, desertion means that one party has left the marriage or partnership without the other's agreement)
- otherwise, a legal husband or wife takes precedence over anyone who is treated as such because they lived with the patient as if they were married, and over anyone who is treated as a relative only because they have lived with the patient for at least five years.

11.14 In addition:

- no-one under 18 can be the nearest relative, unless they are the patient's mother, father, husband or wife (or treated as such); and
- only patients who are not themselves ordinarily resident in Bermuda can have a nearest relative who also does not live in Bermuda. This means tourists, visitors and Bermudians who live abroad (but are visiting Bermuda) can have a nearest relative in the country where they are ordinarily resident.
- In cases where the patient is a child or young person and the Director of Child and Adolescent Services or another designated person has the rights and powers of a parent of the patient, the Director or that person shall be deemed to be the nearest relative of the patient in preference to any person except the patient's husband or wife (if any) [see section 28].

11.15 Tables 2 and 3 at the end of this chapter summarise how these rules are to be used to identify a patient's nearest relative.

## Automatic change of nearest relative

11.16 The identity of the nearest relative will change if the current nearest relative dies or if (for example) the nearest relative is a spouse and the marriage ends.

11.17 It may also change for some other reason not directly involving the existing nearest relative, eg the patient marries, or another relative reaches the age of 18, or comes to live in Bermuda, and therefore becomes eligible to be the nearest relative.

## Appointment of acting nearest relatives by the Magistrates' court

11.18 Under section 29 of the Act, an acting nearest relative can be appointed by the Magistrates' court on the grounds that:

- the nearest relative is incapable of acting as such because of illness or mental disorder
- the nearest relative has objected unreasonably to an application for admission for treatment
- the nearest relative has exercised the power to discharge a patient without due regard to the welfare of the patient or the interests of the public
- the patient has no nearest relative within the meaning of the Act, or it is not reasonably practicable to ascertain whether the patient has a nearest relative or who is that nearest relative

11.19 The effect of a court order appointing an acting nearest relative is to displace the person who would otherwise be the patient's nearest relative.

11.20 The nearest relative of the patient may make an application to the Review Tribunal in respect of the patient within the period of twelve months beginning with the date of the order, and in any subsequent period of twelve months during which the order continues in force.

## The MWO and the nearest relative

11.21 MWOs are required by the Act to attempt to identify the patient's nearest relative as defined in section 8 of the Act (See above). An application for admission to hospital can be made by either the nearest relative (usually in consultation with the MWO) or the MWO.

11.22 When MWOs make an application for admission under section 9 (or an emergency application under section 13), they must take such steps as are practicable to inform the nearest relative and, if different, carer, that the application is to be (or has been) made. Before making the application the MWO is required to form an opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made.

11.23 Before making an application for admission under section 10, MWOs must consult the nearest relative, unless it is not reasonably practicable or would involve unreasonable delay. The application should not be made by the MWO if the nearest relative has notified the officer or the Board that they object to the application being made. In case of admission under section 10, the nearest relative shall also be informed of their power to order discharge subject to section 27 – see 11.18).

11.24 Circumstances in which the nearest relative need not be informed or consulted include those where:

- it is not practicable for the MWO to obtain sufficient information to establish the identity or location of the nearest relative or where to do so would require an excessive amount of investigation involving unreasonable delay
- consultation is not possible because of the nearest relative's own health or mental incapacity.

11.25 There may also be cases where, although physically possible, it would not be reasonably practicable to inform or consult the nearest relative because the detrimental impact of this on the patient would interfere with the patient's right to respect for their privacy and family life to an extent that would not be justified and proportionate in the particular circumstances of the case. Detrimental impact may include cases where patients are likely to suffer emotional distress, deterioration in their mental health, physical harm, or financial or other exploitation as a result of the consultation. Consultation with the nearest relative that interferes with the patient's right to privacy may be justified to protect the patient's right to liberty.

11.26 Consulting and notifying the nearest relative is a significant safeguard for patients. Therefore decisions not to do so on these grounds should not be taken lightly. MWOs should consider all the circumstances of the case, including:

- the benefit to the patient of the involvement of their nearest relative, including to protect the patient's right to liberty
- the patient's wishes including taking into account whether they have the capacity to decide whether they would want their nearest relative involved and any statement of their wishes they have made in advance. However, a patient's wishes will not be determinative of whether it is reasonably practicable to consult the nearest relative.

## Consultation with other people

11.27 Although there are specific requirements to consult the nearest relative, it is important to recognise the value of involving other people in the decision-making process, particularly the patient's carers, family members and advocates, who are often able to provide a particular perspective on the patient's circumstances. In so far as the urgency of the case allows, MWOs should consider consulting with other relevant relatives, carers or friends and should take their views into account.

11.28 In deciding whether it is appropriate to consult carers and other family members, MWOs should consider:

- the patient's wishes
- the nature of the relationship between the patient and the person in question, including how long the relationship has existed
- whether the patient has referred to any hostility between them and the person in question, or there is other evidence of hostility, abuse or exploitation

11.29 MWOs should also consult wherever possible with other people who have been involved with the patient's care, including their case manager if they are supported by community mental health services. This could include people working for statutory, voluntary or independent services and other service providers who do not specialise in mental health services but have contact with the patient (e.g. primary care providers). For example, the patient may be known to services for older people or substance misuse services.

Table 2: Hierarchical list of potential nearest relatives

| SEVEN STEPS TO IDENTIFY THE NEAREST RELATIVE<br>HIERARCHICAL LIST OF POTENTIAL 'NEAREST RELATIVES' | |
|---|---|
| **1st** | Husband or wife (except one permanently separated from the patient by agreement or a court order, or who has deserted or been deserted by the patient) |
| **2nd** | Person who qualifies as a relative by living with the patient as husband or wife |
| **3rd** | Son or daughter aged 18+ |
| **4th** | Father or mother |
| **5th** | Brother or sister aged 18+ |
| **6th** | Half-brother or half-sister aged 18+ |
| **7th** | Grandparent aged 18+ |
| **8th** | Grandchild aged 18+ |
| **9th** | Uncle or aunt aged 18+ of the whole blood |
| **10th** | Uncle or aunt aged 18+ of the half-blood (half-sister of patient's mother) |
| **11th** | Nephew or niece aged 18+ of the whole blood |
| **12th** | Nephew or niece aged 18+ of the half-blood (ie child of a half-brother of the parent or the patient) |
| **13th** | Other person aged 18+ who qualifies as a relative by having lived with the patient for at least 5 years |

Note: Includes relationships made through adoption. Excludes step-relationships.

Table 3: Steps to apply hierarchal list of nearest relatives

| STEPS TO APPLY THE HIERARCHICAL LIST: |
|---|
| *First, determine whether there is a nearest relative.* |
| **Step 1:**<br>Determine whether the patient has anyone who falls into one of the categories of the hierarchical list above. If there is no-one, the patient has no nearest relative. |
| *Second, determine who is likely to be the nearest relative.* |
| **Step 2:**<br>Identify whether there is anyone who falls into one of the categories in the hierarchical list with whom the patient ordinarily resides or by whom the patient is cared for (or, if the patient is currently a hospital inpatient, with whom the patient last ordinarily resided or by whom the patient has cared for before being admitted). If there is someone, skip to step 4. |
| **Step 3:**<br>Identify all the people who meet the criteria in step 1 and then identify the one who comes highest in the hierarchical list as the likely nearest relative. If two or more people come equal first, identify the eldest as the likely nearest relative. Then skip to step 5. |
| **Step 4:**<br>Identify all the people who meet the criteria in step 2 and then determine which one comes highest in the hierarchical list as the likely nearest relative. If two or more people come equal first, identify the eldest as the likely nearest relative. |
| *Third, determine whether the likely nearest relative is actually the nearest relative.* |
| **Step 5:**<br>Determine whether the patient is ordinarily resident in Bermuda. If not, skip to step 7. |
| **Step 6:**<br>Is the likely nearest relative ordinarily resident in Bermuda? If not, return to step 2, but ignore the person who was previously the likely nearest relative. Repeat as necessary. |
| *Fourth, determine the nearest relative.* |
| **Step 7:**<br>The likely nearest relative is indeed the nearest relative, or there is no nearest relative. |

# CHAPTER 12: TREATMENT UNDER THE ACT

## Why read this chapter:

- This chapter gives guidance on medical treatment for mental disorder under the Act, especially treatment given without patients' consent. It also gives guidance on promoting good physical healthcare for patients subject to the Act.

- Treatment under the Act must be appropriate to the patient's mental health condition and take account of the person's wishes or feelings and advance decisions. The chapter provides guidance about appropriate treatment; treatments to which special rules and procedures apply; the treatment of detained patients and patients under CTOs; and on issues of capacity and consent. It gives guidance on treatment plans, explaining their importance, and provides a summary of the treatment of incapacitated patients.

## Definitions

12.1 Although the Bermuda Mental Health Act does not currently have a statutory definition of medical treatment, case law in the UK has established that for those detained under the Act, in addition to medication, it includes nursing, psychological interventions, specialist mental health habilitation, rehabilitation and care offered to alleviate, or prevent a worsening of a mental disorder or one or more of its symptoms or manifestations.

12.2 This includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder (eg treating wounds self-inflicted as a result of mental disorder). Otherwise, the Act does not regulate medical treatment for physical health problems.

12.3 For the purposes of this part of the Act, "consent" in relation to a patient means the voluntary permission of a patient to be given a proposed treatment where sufficient information has been given to the patient about the purpose, nature, likely effects and risks of that treatment. The information should also include the likelihood of its success and any alternatives to it. It is appropriate for treatment to be given to a patient if the treatment is appropriate in their case, taking into account the nature and degree of the mental disorder from which they are suffering and all other circumstances of their case (Section 48Z(b)).

## Appropriate treatment

12.4 All treatment provided should be appropriate to the patient's mental health condition and take account of any wishes or feelings they have expressed in advance of treatment. The practicalities of how the treatment is to be delivered, and how outcomes will be monitored should be considered.

12.5 Where reasonably practicable, treatment should be based on a strong evidence base. Professionals should ensure that any treatment is compliant with the current guidelines and standards about what is appropriate treatment. Examples include National Institute for Health and Care Excellence (NICE, UK), American Psychiatric Association Practice Guidelines (APA, US), or the Canadian Psychiatric Association Clinical Practice Guidelines (CPA, Canada).

12.6 In the case of medications that are used to treat mental disorder, particular care is required when prescribing medications that exceed the maximum dosage listed in the British National Formulary (BNF) or where multiple medications are used to treat a patient.[1] Rationale should be documented in the medical record.

12.7 Unless section 48P (e.g. neurosurgery), section 48Q (medication for mental disorder beyond the three-month period), or 48R (ECT) apply, section 48X of the Act (treatment not requiring consent) means that detained patients may be given medical treatment for any kind for mental disorder, whether they:

- consent to it, or
- have not consented to it,

but the treatment must be given by or under the direction of the responsible medical officer in charge of the treatment in question.

If sections 48P, 48Q or 48R apply, detained patients may be given the treatment only if the rules in those sections are followed.

## Treatment requiring consent and a second opinion (s.48P)

12.8 Section 48P applies to neurosurgery for mental disorder and other treatments as specified by the Minister of Health. It applies to all patients, whether or not they are otherwise subject to the Act.

12.9 Where section 48P applies, these treatments can only be given if all three of the following requirements are met:

- The patient consents to the treatment
- A SOAD, and two other people, not being registered health professionals, but appointed under S48Y, by the Minister, certify in writing that the patient has the capacity to consent to the treatment and has done so
- The SOAD also certifies in writing that it is appropriate for the treatment to be given to the patient

Before giving the certificate, the SOAD will consult two other persons who have been professionally concerned with the patient's medical treatment. One of these persons will be a nurse, and the other will be neither a nurse nor a registered medical practitioner. Neither of them will be the responsible medical officer or the person in charge of the treatment in question.

12.10 A decision to administer treatments to which section 48P applies requires particularly careful consideration, given its significance and sensitivity.

12.11 Before issuing a certificate, the referring professionals and SOAD should personally satisfy themselves that the patient is capable of giving valid consent and is willing to consent. The restrictions and procedures imposed by section 48P should be explained to the patient, and it should be made clear to the patient that their willingness to receive treatment does not necessarily mean that the treatment will be given.

[2] The British National Formulary is available at: https://www.medicinescomplete.com/about/subscribe.htm
See also CR190. Consensus statement on high-dose antipsychotic medication. Royal College of Psychiatrists. 2014.
http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr190.aspx

## Treatments requiring consent or a second opinion under section 48Q

12.12 Section 48Q applies to the administration of medication for mental disorder. But it only applies once three months have passed ('the three-month period') from the day on which any form of medication for mental disorder was first administered to the patient during the current period in which the patient is liable to be detained under the Act.

12.13 For these purposes, the three-month period continues even if the section under which the patient is detained changes or if the patient has withdrawn consent for the treatment. It also includes any time the patient has spent on a CTO. The three-month period is broken if a patient who is detained under part II of the Act is discharged without becoming a CTO patient, or upon the conditional discharge of a restricted patient.

12.14 Section 48Q does not apply to medication administered as part of electro-convulsive therapy (ECT). That is covered by section 48R instead (see paragraphs 12.201 – 12.256 below).

12.15 Section 48Q applies only to detained patients. Detained patients cannot be given medication to which section 48Q applies unless:

- the responsible medical officer (RMO) in charge of the treatment, or a SOAD, certifies that the patient has the capacity to consent and has done so, or
- a SOAD certifies that the treatment is appropriate and either that:
  - the patient does not have the capacity to consent, or
  - the patient has the capacity to consent but has refused to do so.

Before giving the certificate, the SOAD will consult two other persons who have been professionally concerned with the patient's medical treatment. One of these persons will be a nurse, and the other will be neither a nurse nor a registered medical practitioner. Neither of them will be the responsible medical officer or the person in charge of the treatment in question.

12.16 The detaining authority should ensure that systems are in place to remind both the clinician in charge of the medication and the patient at least four weeks before the expiry of the three-month period.

12.17 Warning systems must be capable of dealing with the possibility that a patient may become a CTO patient, and may also have their CTO revoked, during the three-month period. A patient's move between detention and CTO does not change the date on which the three-month period expires.

12.18 Where RMOs certify the treatment of a patient who consents, they should not rely on the certificate as the only record of their reasons for believing that the patient has consented to the treatment. A record of their discussion with the patient including any capacity assessment, should be made in the patient's notes as normal.

12.19 Certificates under this section must clearly set out the specific forms of treatment to which they apply. All the relevant drugs should be listed, including medication to be given 'as required' (prn), either by name or by the classes described in the British National Formulary (BNF). If drugs are specified by class, the certificate should state clearly the number of drugs authorised in each class, and whether any drugs within the class are excluded. The maximum dosage and route of administration should be clearly indicated for each drug or category of drugs proposed. This can exceed the dosages listed in the BNF, but particular care is required in these cases and rationale documented in the medical record.

## Electro-convulsive therapy (requiring consent or a second opinion) under section 48R

12.20 Section 48R applies to ECT and to medication administered as part of ECT. It applies to detained patients.

12.21 The key differences between section 48Q and section 48R are that:

- patients who have the capacity to consent to or refuse treatment may not be given treatment under section 48R unless they do in fact consent
- there is no initial three-month period during which a certificate is not needed (even for the medication administered as part of the ECT)

12.22 A patient who is consenting may not be given treatment under section 48R unless the clinician in charge, or a SOAD, has certified that the patient has the capacity to consent and has done so.

12.23 A patient who lacks the capacity to consent may not be given treatment under section 48R unless a SOAD certifies in writing that the patient lacks capacity to consent and that:

- it is appropriate for the treatment to be given and
- the treatment will not conflict with:
  - any previous wishes made by the patient, which the concerned SOAD is satisfied are valid and applicable, to refuse the treatment in question, or
  - a decision made by a judge appointed under Part IV of the Act or via a power of attorney

Before giving the certificate, the SOAD will consult two other persons who have been professionally concerned with the patient's medical treatment. One of these persons will be a nurse, and the other will be neither a nurse nor a registered medical practitioner. Neither of them will be the responsible medical officer or the person in charge of the treatment in question.

12.24 In all cases, SOADs should indicate on the certificate the maximum number of administrations of ECT that are approved.

12.25 Whether or not section 48R applies, all patients who are to be treated with ECT should be given written information before their treatment starts which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose and likely effects.

# CHAPTER 13: COMMUNITY TREATMENT ORDERS

## Why read this chapter?

- The purpose of a community treatment order (CTO) is to allow suitable patients to be treated safely in the community rather than in hospital; this chapter gives guidance on CTOs. Hospital managers, Mental Welfare Officers and responsible medical officers should, in particular, note the guidance in this chapter.

- This chapter provides guidance about the use of CTOs, patients for whom they are suitable, and providing and managing care planning and support in the community. Certain conditions may be attached to a CTO and information should be provided for patients and others about the CTO. The chapter includes guidance on circumstances that might lead to recall to hospital, the procedures that should be followed, revoking a CTO, reviewing a CTO, and discharging patients from a CTO.

- In accordance with the guiding principles of the Act (chapter 4), patients, and where appropriate, their families and carers should be fully involved in decisions. Treatment should be the least restrictive option and should aim to maximise independence.

## Purpose of a CTO

13.1 The purpose of a Community Treatment Order (CTO) is to allow suitable patients to be safely treated in the community rather than under detention in hospital. They provide a way to help prevent relapse and any harm, to the patient or to others, that might occur without continued oversight. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. The principles of treating patients using the least restrictive option, maximising their independence, and purpose and effectiveness should always be taken account of when considering CTOs.

13.2 A CTO provides a framework for the management of patient care in the community and gives the responsible medical officer the power to recall the patient to hospital for treatment if necessary.

## Treatment of CTO patients not recalled to hospital (Part IIIC patients)

13.3 Part IIIC of the Act sets out different rules for treatment for patients on CTOs who have not been recalled to hospital by their responsible medical officer. This includes patients on CTOs who are in hospital without having been recalled (e.g. if they have been admitted to hospital voluntarily).

13.4 The rules for community patients not recalled to hospital differ depending on whether or not they have the capacity to consent to or refuse the treatment in question. Except where otherwise stated, references in the paragraphs below are to a person who lacks capacity to consent to or refuse treatment.

13.5 Community patients not recalled to hospital, who have the capacity to consent to or refuse a treatment, may not be given that treatment unless they consent. There are no exceptions to this rule, even in emergencies. The effect is that treatment can be given without their consent only if they are recalled to hospital.

13.6 For patients on CTOs, who lack the capacity to consent to or refuse a treatment, it may be given if someone who is a donee of a power of attorney or a Receiver who has been appointed by a judge under Part IV of the Act consents on their behalf.

13.7 Emergency treatment may be given to patients on CTOs who lack the capacity to consent to a treatment if the following conditions are satisfied:

- When giving the treatment, the person reasonably believes that the patient, lacks capacity to consent to it, and
- The treatment is immediately necessary (examples of the situations which might meet this definition are set out in s48.1E(5), and
- If it is necessary to use force in order to give the treatment-
  - o The treatment needs to be given in order to prevent harm to the patient, and
  - o The use of such force is a proportionate response to the likelihood of the patient suffering harm, and to the seriousness of that harm.

13.8 In deciding whether patients object to treatment, all the relevant evidence should be taken into account, so far as it reasonably can be. In many cases, patients will be perfectly able to state their objection, either verbally or by their dissenting behaviour. In other cases, especially where patients are unable to communicate (or only able to communicate to a limited extent), professionals will need to consider the patient's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained.

13.9 If there is reason to think that a patient would object, if able to do so, then the patient should be taken to be objecting. Occasionally, it may be that the patient's behaviour initially suggests an objection to being treated, but is in fact not directed at the treatment at all. In that case the patient would not be taken to be objecting.

## Who can be discharged using a CTO?

13.10 Only patients who are detained in hospital for treatment under section 10, section 33, or section 44 (if the latter two are without restrictions under section 38 or 45 respectively) can be considered for a CTO.

13.11 A CTO is an option only for patients who meet the criteria set out in the Act, which are that:

- the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
- it is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment;
- subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital; and
- it is necessary that the responsible medical officer should be able to exercise the power under section 48H of the Act to recall the patient to hospital

13.12 The decision as to whether a CTO is the right option for any patient is taken by the RMO and requires the agreement of an MWO. The RMO should consider the principles, in particular the least restrictive option and maximising independence principle. A CTO may be used only if it would not be possible to achieve the desired objectives for the patient's care and treatment without it. In particular, the responsible medical officer should consider whether the power to recall the patient is necessary and whether the

patient can be treated in the community without that power. Consultation at an early stage with the patient and those involved in the patient's care, including family and carers will be important.

13.13 In assessing the patient's suitability for a CTO, the responsible medical officer must be satisfied that the patient requires medical treatment for mental disorder for their own health or safety or for the protection of others.

13.14 In making a decision to place the patient on a CTO, the responsible medical officer must assess what risk there would be of the patient's condition deteriorating after discharge, e.g. as a result of refusing or neglecting to receive treatment.

13.15 In assessing that risk, the responsible medical officer should take into consideration the patient's history of mental disorder, previous experience of contact with services and engagement with treatment. A tendency to fail to follow a treatment plan or to discontinue medication in the community, and then relapsing may suggest a risk justifying use of a CTO rather than discharge into voluntary community care.

13.16 Other relevant factors will vary, but are likely to include the patient's current mental state, the patient's capacity to make decisions about their care and treatment and attitude to treatment and risk of relapse, the circumstances into which the patient would be discharged, and the willingness and ability of family and/or carers to provide support (especially where aspects of the care plan depend on them).

13.17 A risk that the patient's condition will deteriorate is a significant consideration, but does not necessarily mean that the patient should be discharged onto a CTO rather than discharged. The responsible medial officer must be satisfied that the risk of harm arising from the patient's disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment. CTOs should only be used when there is reasonable evidence to suggest that there will be benefits to the individual. Such evidence may include:

- a clear link between non concordance with medication and relapse sufficient to have a significant impact on wellbeing requiring treatment in hospital
- clear evidence that there is a positive response to medication without an undue burden of side effects
- evidence that the CTO will promote recovery
- evidence that recall may be necessary (rather than voluntary admission or reassessment under the Act)

13.18 Patients do not have to give formal consent to a CTO. However, patients should be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to co-operate with the proposed treatment. The responsible medical officer should inform the patient of the essential legal and factual grounds for the CTO and other information about the CTO both orally and in writing.

## Action upon Review Tribunal recommendation

13.19 When a detained patient makes an application to the Review Tribunal for discharge, the Tribunal may decide not to order discharge, but to recommend that the responsible medical officer should consider a CTO. In that event, the responsible medical officer should carry out the assessment of the patient's suitability in the usual way. It will be for the responsible medical officer to decide whether or not a CTO

is appropriate for that patient taking into account the factors outlined above. The responsible medical officer should record the reasons for their decision in the patient's medical record.

## Conditions to be attached to the CTO

13.20 The CTO includes conditions with which the patient is required to comply. There are two conditions which must be included in all cases. Patients are required to make themselves available for medical examination:

- when needed for consideration of extension of the CTO
- if necessary, to allow a second opinion approved doctor (SOAD) to provide a part IIIC certificate authorising treatment

13.21 Responsible medical officers may also, with the MWO's agreement and following discussions with the patient, set other conditions which are identified as being necessary or appropriate to:

- ensure that the patient receives medical treatment for mental disorder
- prevent a risk of harm to the patient's health or safety as a result of mental disorder
- protect other people from a similar risk of harm

13.22 The conditions must not deprive the patient of their liberty and should:

- be kept to a minimum number consistent with achieving their purpose
- restrict the patient's liberty as little as possible while being consistent with their care plan and recovery goal
- have a clear rationale, linked to one or more of the purposes in paragraph 13.20 above
- be clearly and precisely expressed, so that the patient can readily understand what is expected

13.23 The nature of the conditions will depend on the patient's individual circumstances. They should be stated clearly having regard to the least restriction principle. Subject to paragraph 13.21, they might cover matters such as:

- where and when the patient is to receive treatment in the community
- where the patient is to live
- avoidance of known risk factors or high-risk situations relevant to the patient's mental disorder

13.24 The reasons for any condition should be explained to the patient and others, as appropriate, (e.g. family and carers) and recorded in the patient's notes. It will be important, if the CTO is to be successful, that the patient agrees to keep to the conditions, or to try to do so, and that patients have access to the help they need to be able to comply. It is helpful if families can have access to support so they can help the patient to comply. The patient should have a discharge meeting and a copy of the care plan before they are discharged from hospital onto the CTO.

## Monitoring CTO patients

13.25 It will be important to maintain contact with a patient on a CTO and to monitor closely their mental health and wellbeing after they leave hospital. The type and scope of the arrangements will vary depending on the patient's needs and individual circumstances. All those involved will need to agree to the arrangements. Respective responsibilities should be clearly set out in the patient's care plan. The case

manager would normally be responsible for coordinating the care plan, working with the responsible medical officer, the team responsible for the patient's care, family carers and any others with an interest.

13.26 Appropriate action will need to be taken if the patient becomes unwell, engages in high-risk behaviour as a result of mental disorder or withdraws consent to treatment (or begins to object to it). The responsible medical officer should consider, with the patient (and others where appropriate), the reasons for any such changes and what the next steps should be. If the patient refuses crucial treatment, an urgent review of the situation will be needed, and recalling the patient to hospital will be an option if the risk justifies it. If suitable alternative treatment is available which would allow the patient to continue safely on a CTO and which the patient would accept, the responsible medical officer should consider such treatment if this can be offered. If so, the treatment plan, and if necessary the conditions of the CTO, should be varied accordingly (note that a revised part IIIC certificate may be required).

## Recall to hospital

13.27 The recall power is intended to provide a means to respond to evidence of relapse or high-risk behaviour relating to mental disorder before the situation becomes critical and leads to the patient or other people being harmed. The need for recall might arise as a result of relapse, or by a change in the patient's circumstances giving rise to increased risk. The responsible medical officer does not have to interview or examine the patient in person before deciding to recall them.

13.28 The responsible medical officer may recall a patient on a CTO to hospital for treatment if:

- the patient needs to receive treatment for mental disorder in hospital (either as an in-patient or as an out-patient), and
- there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled.

13.29 A patient may also be recalled to hospital if they break either of the mandatory conditions which must be included in all CTOs – that is, by failing to make themselves available for medical examination either to allow consideration of extension of the CTO or to allow a SOAD to give a part IIIC certificate for proposed section 48Q or section 48R treatment (see paragraphs 12.12 to 12.25). The patient must always be given the opportunity to comply with the condition before recall is considered, unless there is a risk of harm to their health or safety or to others. Before exercising the recall power for this reason, the responsible medical officer should consider whether the patient has a valid reason for failing to comply, and should take any further action accordingly.

13.30 The responsible medical officer must be satisfied that the criteria are met before using the recall power. Any action should be proportionate to the level of risk. For some patients, the risk arising from a failure to comply with treatment could indicate an immediate need for recall. In other cases, negotiation with the patient and (unless the patient objects or it is not reasonably practicable) the nearest relative, carers and, in the case of children and young people, person(s) with parental responsibility, may resolve the problem and so avert the need for recall.

13.31 The responsible medical officer should consider in each case whether recalling the patient to hospital is justified in all the circumstances. For example, it might be sufficient to monitor a patient who has failed

to comply with a condition to attend for treatment, before deciding whether the lack of treatment means that recall is necessary. A patient might agree to admission to hospital on a voluntary basis. Failure to comply with a condition (apart from those relating to availability for medical examination, as above) does not in itself trigger recall. Only if the breach of a condition results in an increased risk of harm to the patient or to anyone else will recall be justified.

13.32 It might be necessary to recall a patient whose condition was deteriorating despite compliance with treatment, if the risk cannot be managed otherwise.

13.33 Recall to hospital for treatment should not become a regular or routine event for any patient on a CTO. If recall is being used frequently, the responsible medical officer should review the patient's treatment plan to consider whether it could be made more acceptable to the patient, or whether, in the individual circumstances of the case, a CTO continues to be appropriate.

## Procedure for recall to hospital

13.34 The responsible medical officer has responsibility for coordinating the recall process, unless it has been agreed that responsibility be delegated to someone else. It will be important to ensure that the practical impact of recalling the patient on the patient's domestic circumstances is considered and managed. For example, wherever possible the responsible medical officer should verbally give the patient (or arrange for the patient to be given) reasons for the recall before it happens, taking into account any risks arising from giving notice of the recall. The family and carers involved in providing support to the patient should also be informed.

13.35 In every case the responsible medical officer must complete a written notice of recall to hospital, which is effective only when served on the patient. A copy of the notice should be kept in the notes to be available to the on call team who may be required to follow-up the recall process. It is important that, wherever possible, the notice should be handed to the patient personally. Otherwise, the notice is served by delivery to the patient's usual or last known address.

13.36 Once the recall notice has been served, the patient can, if necessary, be treated as absent without leave, and taken and transported to hospital (and a patient who leaves the hospital without permission can be returned there). The time at which the notice is deemed to be served will vary according to the method of delivery.

13.37 It will not usually be appropriate to post a notice of recall to the patient. This may, however, be an option if the patient has failed to attend for medical examination as required by the conditions of the CTO, despite having been requested to do so, when the need for the examination is not urgent and it will be important to allow sufficient time for the patient to receive the notice before any action is taken to ensure compliance.

13.38 Where the need for recall is urgent, as will usually be the case, it will be important that there is certainty as to the timing of delivery of the notice. A notice handed to the patient is effective immediately. It may not be possible to achieve this if the patient's whereabouts are unknown or if the patient is unavailable or simply refuses to accept the notice. In that event the notice should be delivered by hand to the patient's usual or last known address. The notice is then deemed to be served (even though it may not actually

be received by the patient) on the day after it is delivered – that is, the day (which does not have to be a working day) beginning immediately after midnight following delivery.

13.39 If the patient's whereabouts are known but access to the patient cannot be obtained, it might be necessary to consider whether a warrant is needed.

13.40 The patient should be transported to hospital in the least restrictive manner possible. If appropriate, the patient may be accompanied by a family member, carer or friend.

13.41 The responsible medical officer should ensure that the hospital is ready to receive the patient and to provide appropriate treatment. While recall must be to a hospital, the required treatment may then be given on an outpatient basis, if appropriate.

13.42 When the patient arrives at hospital after recall, the clinical team will need to assess the patient's condition, provide the necessary treatment and determine the next steps. The patient may be well enough to return to the community once treatment has been given, or may need a longer period of assessment or treatment in hospital. The patient may be detained in hospital for a maximum of 72 hours after recall to allow the responsible medical officer to determine what should happen next. During this period the patient remains a CTO patient, even if they remain in hospital for one or more nights. The responsible medical officer may allow the patient to leave the hospital at any time within the 72-hour period. Once 72 hours from the time of admission have elapsed, the patient must be allowed to leave if the responsible medical officer has not revoked the CTO. On leaving hospital the patient will remain on the CTO as before.

13.43 In considering the options, the responsible medical officer and the clinical team will need to consider whether a CTO remains the right option for that patient. They will also need to consider, with the patient, the nearest relative (subject to the normal considerations about involving nearest relatives), and any carers (and in the case of children and young people, those with parental responsibility), what changes might be needed to help to prevent the circumstances that led to recall from recurring. It may be that a variation in the conditions is required, or a change in the care plan (or both).

## Revoking the CTO

13.44 If the patient requires inpatient treatment for longer than 72 hours after arrival at the hospital, the responsible medical officer should consider revoking the CTO. The effect of revoking the CTO is that the patient will again be detained under the powers of the Act. The responsible medical officer and an MWO should reassess the patient before revoking their CTO. They must do so if necessary to satisfy themselves that the patient again needs to be admitted to hospital for medical treatment under the Act.

13.45 The CTO may be revoked if:

- the responsible medical officer considers that the patient again needs to be admitted to hospital for medical treatment under the Act, and
- an MWO agrees with that assessment, and also believes that it is appropriate to revoke the CTO.

13.46 In making the decision as to whether it is appropriate to revoke a CTO, the MWO should consider the wider social context for the person concerned, in the same way as when making decisions about applications for admissions under the Act.

13.47 As before, the MWO carrying out this role may (but need not) be already involved in the patient's care and treatment.

13.48 If the MWO does not agree that the CTO should be revoked, then the patient cannot be detained in hospital after the end of the maximum recall period of 72 hours. The patient will therefore remain on a CTO. A record of the MWO's decision and the full reasons for it should be kept in the patient's notes. It would not be appropriate for the responsible medical officer to approach another MWO for an alternative view.

13.49 If the responsible medical officer and the MWO agree that the CTO should be revoked, they must complete the relevant statutory form for the revocation to take legal effect, and send it to the hospital Board. The responsible medical officer or the MWO must give the patient (or arrange for the patient to be given) oral reasons for revoking the CTO before it is revoked. The patient is then detained again under the powers of the Act exactly as before going onto a CTO, except that a new detention period of twelve months begins for the purposes of review and applications to the Tribunal. Written reasons for the revocation should also be given to the patient and (where appropriate) their nearest relative. The hospital Board should notify the patient and (where appropriate) their nearest relative when they have referred the patient's case to the Tribunal.

## Review of patient's CTOs

13.50 In addition to the statutory requirements in the Act for review of CTOs, it is good practice to review the patient's progress on their CTO as part of all reviews of the care plan or its equivalent.

13.51 Reviews should cover whether the CTO is meeting the patient's treatment needs and, if not, what action is necessary to address this. A patient who no longer satisfies all the criteria for being on a CTO must be discharged without delay.

## Discharge from a CTO

13.52 It is very important that patients should not remain subject to a CTO once it is no longer necessary, i.e. if the answer to any of the following questions is 'no':

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment?
- If so, is it necessary in the interests of the patient's health or safety or for the protection of other persons that the patient should receive such treatment?
- Is it still necessary for the responsible medical officer to be able to exercise the power to recall the patient to hospital, if that is needed? (e.g. the longer a patient has been on a CTO without the need to exercise the power to recall them to hospital, the more important it will become to question whether this criterion is still satisfied).

13.53 CTO patients may be discharged in the same way as detained patients, by the responsible medical officer, by the Chief of Psychiatry, by the nearest relative of the patient or by the Tribunal. The responsible medical officer may discharge a CTO patient at any time and must do so if the patient no longer meets the criteria for a CTO. A patient's CTO should not simply be allowed to lapse.

13.54 The reasons for discharge should be explained to the patient, and any concerns on the part of the patient, the nearest relative or any carer should be considered and dealt with as far as possible. On discharge from a CTO, the mental health team should ensure that any after-care services the patient continues to need will be available.

# CHAPTER 14: APPOINTMENT, SELECTION AND UTILIZATION OF SOADS

14.1 The second opinion approved doctor (SOAD) is a registered medical practitioner who:

- Is a specialist in psychiatry; or
- Is qualified to practice as a psychiatrist by virtue of a qualification recognised by the Bermuda Medical Council; and
- Is appointed as a SOAD by the Minister in accordance with the Code

14.2 The treatment proposals for the patient, together with the notes of any relevant multi-disciplinary discussion, must be made available to the SOAD before or at the time of a visit or assessment. The SOAD must have access to the relevant people whom they need to meet; at the least, this should be by telephone. SOADs have the right to access records without the patient's consent, if necessary, but only those records relating to the treatment in the hospital. The SOAD's attention should be drawn to any recent review of the patient's medication, or other treatment.

14.3 The SOAD is required to give their opinion and complete the relevant reports in the following situations:

- Treatment that requires both consent and a second opinion (S48P). This applies to any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue
- Treatment that requires consent or a second opinion (S48Q). This applies to the administration of medication whilst the person is detained as a patient, where the period of 3 months has elapsed since the first occasion in that period when medicine was administered
- Treatment involving electro-convulsive therapy where consent or a second opinion is required (S48R)
- Community Treatment Order patients who have not been recalled to hospital (S48(1)(b)) in circumstances where a Part IIIC certificate is required

14.4 The responsibilities of the SOAD include that they should:

- Satisfy themselves that detention papers are in order
- Interview the patient in private if possible
- Consult with two people (statutory consultees). One must be a nurse; the other must not be a nurse or a doctor. Both must have been professionally concerned with the patient's medical treatment but neither may be the clinician in charge of the proposed treatment or the responsible medical officer.
- Be prepared, where appropriate, to consult other concerned people (e.g. the GP, family, carers and advocates)
- Consider the clinical appropriateness of the treatment and its appropriateness in the light of all the circumstances of the patient's case
- Provide written reasons in support of their decisions to approve specific treatments and an indication whether, in their view, disclosure of these reasons to the patient would be likely to cause serious harm to the patient's physical or mental health or that of any other person
- Inform the clinician in charge of treatment as soon as possible of any disagreement with the treatment plan

# CHAPTER 15: APPOINTMENT & QUALIFICATIONS OF MENTAL WELFARE OFFICERS

15.1 The role of the Mental Welfare Officer (MWO) is to coordinate the assessment of patients who are being considered for assessment under the Act. The MWO provides a counterbalance to the role of the medical practitioner. In order for decisions about compulsion to be both objective and appropriate the MWO brings to the role what can be summarised as being a 'social perspective'. The MWO focuses on the overall circumstance of the patient's situation, including issues and educational factors that may affect the patient including the needs of that patient for assessment and treatment. Specifically, that may include:

- Considering the issues of concern in a way that attempts to engage and involve the patient
- Ensuring that any interventions are the least restrictive possible and are in strict compliance with the law; this includes the Mental Health Act and appropriate Human Rights legislation
- Taking into account the wishes of relatives and all other relevant circumstances

15.2 The main responsibilities of the MWO are to:

- Consider making applications for admission of a patient for assessment or treatment. When satisfied that such an application ought to be made under sections 9, 10, or 13, they will complete the necessary report
- Consider whether they support the opinion of the responsible medical officer in situations where a Community Treatment Order (CTO) is being recommended, and whether it is appropriate to make the order
- Set out with the Responsible Medical Officer (RMO), any conditions that are to be applied to the order if a CTO is made
- Consider whether it is appropriate to extend the period of a CTO
- Consult with the RMO regarding the action to be taken in a situation where a community patient is absent without leave for more than 28 days
- Furnish reports regarding the revocation of a CTO

15.3 MWOs may make an application for detention only if they:

- have interviewed the patient in a suitable manner,
- have, where possible, ascertained that the Nearest Relative does not object,
- are satisfied that the statutory criteria for detention are met, and
- are satisfied that, in all the circumstances of the case, detention in hospital is the most appropriate way of providing the care and medical treatment the patient needs.

15.4 Once an MWO has decided that an application should be made, they must then decide whether it is necessary or proper for them (rather than the nearest relative) to make the application. If, having considered any views expressed by the patient's relatives and all the other relevant circumstances, they decide that it is appropriate to make the application, the MWO must do so.

15.5 At the start of an assessment, MWOs should identify themselves to the person being assessed, members of the family, carers or friends and the other professionals present. When an MWO makes an application for admission under section 9, they must take such steps as are practicable to inform the nearest relative and, if different, carer, that the application is to be (or has been) made. Before making an application for admission under section 10, MWOs must consult the nearest relative, unless it is not reasonably practicable or would involve unreasonable delay.

15.6 If they do not consult or inform the nearest relative, MWOs should record their reasons. Consultation must not be avoided purely because it is thought that the nearest relative might object to the application. When consulting nearest relatives, MWOs should, where possible:

- Ascertain the nearest relative's views about both the patient's needs and the nearest relative's own needs in relation to the patient
- Inform the nearest relative of the reasons for considering an application for detention and what the effects of such an application would be
- Inform the nearest relative of their role and rights under the Act

15.7 MWOs are appointed by the Minister of Health to undertake the roles outlined in paragraphs 15.1 to 15.6; they do not have to be employees of Bermuda Hospitals Board. For initial appointment, MWOs are required to have the following qualifications and experience:

- Successful completion of a programme of academic training to demonstrate competency to practice clinical nursing, counselling, social work, psychology, psychiatry or equivalent related field
- Registered with the relevant statutory body in Bermuda as applicable
- Has Bermudian status or the right to work in Bermuda
- At least 5 years post graduate experience in the field of mental health/psychiatry
- At least 5 years' experience assessing mental health risks in the community or within a hospital setting, of which 3 or more years are in a facility providing mental health assessments
- Demonstrated ability to undertake all the duties of the Mental Welfare Officer as outlined in the Mental Health Act
- Successful completion of an MWO course (local or international)
- Is a fit and proper person to be appointed as an MWO

15.8 For re-appointment every three years, MWOs are required to demonstrate:

- Continuing education to meet the qualifications, experience and conduct required to undertake all duties
- At least 100 hours of MWO service per year
- Is a fit and proper person to be appointed as an MWO

# APPENDIX I: KEY WORDS AND PHRASES

| TERM | DEFINITION | PARAGRAPHS |
| --- | --- | --- |
| **Absent without leave (AWOL)** | When a patient absconds from legal custody in the following circumstances: when a detained patient leaves hospital without getting permission first or does not return to hospital when required to do so; and when CTO patients and conditionally discharged restricted patients don't return to hospital when recalled, or leave the hospital without permission after they have been recalled. | 13.34 – 13.43 |
| **The Act** | Unless otherwise stated, the Mental Health Act 1968 and Mental Health Amendment Act 2019. | |
| **Application for detention** | An application made by a Mental Welfare Officer, or a nearest relative, under Part 2 of the Act for a patient to be detained in a hospital either for assessment or for medical treatment. Applications may be made under section 9 (application for admission for assessment), section 10 (application for admission for medical treatment) or section 13 (emergency application for admission for assessment). | 10.1 – 10.22 |
| **Assessment** | Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention should be made. | 10.19 – 10.22 |
| **Best Interests** | The process used to weigh up the various factors in order to work out what is in a person's best interests when the person lacks the capacity to make a particular decision. | 9.11 |
| **Blanket restrictions** | A blanket restriction or a blanket restrictive practice is any practice that restricts the freedom (including freedom of movement and communication with others) of all patients on a ward or in a hospital, which is not applied on the basis of an analysis of the risk to the individual or others. | 7.2 – 7.10 |
| **The Board** | Means the Bermuda Hospitals Board established under the Bermuda Hospitals Board Act 1970 | 10.20, 13.49, Appendix IV |

| TERM | DEFINITION | PARAGRAPHS |
|---|---|---|
| **Capacity** | The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack capacity to take a particular decision (e.g. to consent to treatment) because they cannot understand, retain, use or weigh the information relevant to the decision. See also competence to consent. | 9.1 – 9.15<br>10.12 – 10.14<br>13.4 – 13.8 |
| **Certificate required** | Whether or not part IIIC patients consent to treatment, there are certain treatments they can only be given if they have been approved by a SOAD on a 'part IIIC certificate' (see paragraph 12.8 to 12.11). The Act refers to this as the 'certificate requirement', which is above and beyond the requirements described above, which the Act calls the 'authority' to give treatment. Broadly speaking, the certificate requirement applies to any treatment for which a certificate would be necessary under section 48P or 48Q or 48R of the Act were the patient is detained instead (see chapter 12). | 12.8 – 12.11<br>12.20 – 12.25 |
| **Community patient** | A patient who is supervised on a community treatment order. | Chapter 13 |
| **Community Treatment Order (CTO)** | The legal authority for the discharge of a patient from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary. Community patients are expected to comply with the conditions specified in the community treatment order. | 6.6 – 6.14<br>6.16 – 6.19<br>13.1 – 13.54 |
| **Compulsory measures** | Things which can be done under the Act without a person's agreement. This includes detention in hospital, and in the community under a community treatment order. | 6.6 – 6.19<br>7.20 – 7.21<br>10.13 – 10.22<br>Appendix II |
| **Compulsory treatment** | Medical treatment for mental disorder given under the Act, which may be against the wishes of the patient. | 6.9 – 6.19<br>10.2 – 10.18<br>12.1 – 12.25<br>Appendix II |
| **Conditional discharge** | The discharge from hospital by the Minister of Health or the Tribunal of a restricted patient subject to conditions. The patient remains subject to recall to hospital by the Minister of Health. | Appendix II |

| TERM | DEFINITION | PARAGRAPHS |
|---|---|---|
| **Consent** | Agreeing to allow someone else to do something to, or for, you. Particularly consent to treatment. Valid consent requires that the person has the capacity to make the decision (or the competence to consent, if a child), that they are given the information they need to make the decision, and that they are not under any duress or inappropriate pressure. | 6.15<br>9.1<br>12.3<br>12.8 – 12.25<br>13.18<br>13.24 |
| **Consultant Psychiatrist** | A medical practitioner who is registered as a specialist in psychiatry by the Bermuda Medical Council under the Medical Practitioners' Act 1950. | 10.20<br>Appendix III |
| **Criteria for detention** | A set of criteria that must be met before a person can be detained, or remain detained, under the Act. The criteria are different under different sections of the Act. | 6.9 – 6.13 |
| **Detained patient** | Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital. | 10.2 – 10.8<br>13.1 – 13.11 |
| **Detention for assessment (and detained for assessment)** | The detention of a person in order to carry out an assessment. Can normally only last for a maximum of 28 days. Also known as 'section 9 detention'. Sometimes colloquially referred to as "sectioning" | 10.1 – 10.22 |
| **Detention for medical treatment (and detained for medical treatment)** | The detention of a person in order to give them the medical treatment they need for the mental disorder. There are various types of detention for medical treatment in the Act. It most often means detention as a result of an application for detention under section 10 of the Act. It also includes several types of detention under Part III of the Act, including hospital orders and transfer directions. | 10.3 – 10.8<br>12.1 – 12.25 |

| TERM | DEFINITION | PARAGRAPHS |
|---|---|---|
| **Discharge** | Unless otherwise stated, a decision that a patient should no longer be subject to detention, community treatment order, or conditional discharge. Discharge from detention is not the same as being discharged from hospital. The patient might already have left hospital on leave of absence, or might agree to remain in hospital as a voluntary patient. | 13.16<br>13.18<br>13.51 – 13.53<br>Appendix II<br>13.10 – 13.19<br>13.52 – 13.54<br>Appendix II |
| **Electro-convulsive therapy (ECT)** | A form of medical treatment for mental disorder in which a small, carefully controlled electric current is introduced into the brain. It is administered in conjunction with a general anaesthetic and muscle relaxant medications and is occasionally used to treat very severe depression. | 12.20 – 12.25 |
| **Emergency application** | An application for detention for assessment made under section 13 with only one supporting medical recommendation in cases of urgent necessity. | Appendix III |
| **Guiding principles** | Nine overarching principles that should be considered when making decisions in relation to mental health care, support and treatment. | 3.4<br>Chapter 4 |
| **Intellectual disability** | An intellectual disability means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning. The term “intellectual disability” is widely used in clinical practice as an alternative to “mental impairment”. | 5.15 – 5.17 |
| **Leave of absence** | Permission for a patient who is detained in hospital to be absent from the hospital for short periods e.g. to go to the shops or spend a weekend at home, or for much longer periods. Patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interest of the patient’s health or safety or for the protection of other people. | |
| **Medical recommendation** | Normally means a recommendation provided by a medical practitioner in support of an application for detention. | 10.15 – 10.22<br>Appendix II<br>Appendix III |

| TERM | DEFINITION | PARAGRAPHS |
|---|---|---|
| **Medical treatment** | In the Act, this covers a wide range of services. As well as the kind of care and treatment given by medical practitioners, for the purposes of the Act, it also includes nursing, psychological therapies, and specialist mental health rehabilitation and care. | 12.1 – 12.25 |
| **Mental disorder** | A mental illness, arrested or incomplete development of mind, severe personality disorder, and any other disorder or disability of mind; and "mentally disordered" shall be construed accordingly. | 5.1 – 5.17 |
| **Mental illness** | An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia. | 5.1 – 5.7 |
| **Mental impairment** | A state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned, and "mentally impaired" shall be construed accordingly. | 5.2<br>5.15 – 5.17 |
| **Mental Welfare Officer (MWO)** | A registered clinician who coordinates the assessment of patients who are being considered for assessment under the Act. | 10.19 – 10.22<br>11.3<br>11.21 – 11.29<br>13.12 – 13.52<br>15.1 – 15.8 |
| **Nearest relative** | A person defined by section 8 of the Act who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative. | 6.24 – 6.29<br>11.1 – 11.29 |
| **Part II** | The part of the Act which deals with detention, and community treatment orders for civil (i.e. non-offender) patients. Some aspects of Part II also applies to some patients who have been transferred from prison to detention in hospital by the Minister of Health under Part III of the Act. | 10.1 – 10.22 |

| TERM | DEFINITION | PARAGRAPHS |
|---|---|---|
| **Part III** | The part of the Act which deals with mentally disordered offenders and defendants in criminal proceedings. Among other things, it allows courts to detain people in hospital for treatment instead of punishing them, where particular criteria are met. It also allows the Minister of Health to transfer people from prison to detention in hospital for treatment. | Appendix II |
| **Part IIIA** | The part of the Act which deals with Community Treatment Orders. Among other things, it allows the responsible medical officer to make an order in writing discharging a detained patient from hospital. The patient may be liable to recall to hospital in the event that they require medical treatment in hospital and there would be a risk of harm to the health and safety of the patient or to other persons if they were not recalled to hospital. | 13.1 – 13.54<br>Appendix II<br>Appendix III |
| **Part IIIB** | The part of the Act which deals mainly with the medical treatment for mental disorder of detained patients (including community patients who have been recalled to hospital). In particular, it sets out when they can and cannot be treated for their mental disorder without their consent. | 12.1 – 12.25 |
| **Part IIIC** | The part of the Act which deals with the treatment of community patients who are not recalled to hospital. Among other things it sets out the giving of relevant treatment to a community patient who is not recalled to hospital. | 13.1 – 13.54 |
| **Part IV** | The part of the Act which deals with the management of property and affairs of patients. Among other things it sets out how the Chief Justice or a Puisne Judge should administer the affairs of a patient who is deemed unable to manage or administer their own property and affairs. | 7.11 – 7.12<br>7.15 – 7.23 |

| TERM | DEFINITION | PARAGRAPHS |
|---|---|---|
| **Part V** | The part of the Act which sets out the circumstances in which an application may be made to the Review Tribunal. Among other things it sets out the powers and roles of the Review Tribunal. It also sets out the consequences of ill treatment or willful neglect of a patient, and the offence of sexual intercourse with patients. | 4.23 – 4.25<br>6.16 – 6.19<br>7.13<br>13.19, 13.49, 13.53<br>Appendix III |
| **Patient** | A person who is, or appears to be, suffering from a mental disorder. This use of the term is not a recommendation that the term 'patient' should be used in practice in preference to other terms such as 'service user', 'client' or similar terms. It is just a reflection of the terminology used in the Act itself. | 5.1 – 5.8 |
| **Recall (and recalled)** | A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on a community treatment order, or who have been given a conditional discharge from hospital. | 6.14<br>13.26 – 13.49 |
| **Responsible Medical Officer (RMO)** | The consultant psychiatrist in charge of the psychiatric care of that patient and includes the Chief of Psychiatry and any consultant psychiatrist designated by the Chief of Psychiatry to be in charge of the psychiatric care of that patient during the absence of the responsible medical officer. Certain decisions (such as renewing a patient's detention or placing a patient on a community treatment order) can only be taken by the responsible medical officer. | 10.20,<br>13.2 – 13.3,<br>13.11 – 13.20<br>13.25 – 13.54 |
| **Revocation (and revoke)** | Term used in the Act to describe the rescinding of a community treatment order (CTO) when a community patient needs further treatment in hospital under the Act. If a patient's CTO is revoked, the patient is detained under the powers of the Act in the same way as before the CTO was made. | 13.44 – 13.49 |

| TERM | DEFINITION | PARAGRAPHS |
|---|---|---|
| **Second Opinion Appointed Doctor (SOAD)** | An independent medical practitioner appointed by the Minister who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent. | 12.9 – 12.24<br>14.1 – 14.4<br>Appendix V |
| **Section 12 approved doctor** | A medical practitioner approved by the Board as having special experience in the diagnosis or treatment of mental disorder. | 10.20<br>Appendix II<br>Appendix III<br>Appendix V |
| **Severe mental impairment** | A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "severely mentally impaired" shall be construed accordingly. | 5.2<br>5.14 |
| **SOAD certificate** | A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient. | 12.9 – 12.11<br>12.15 – 12.19<br>12.21 – 12.24 |
| **Statutory consultees** | The SOAD must consult with two people (statutory consultees) in order to make their assessment. One must be a nurse; the other must not be a nurse or a doctor. Both must have been professionally concerned with the patient's medical treatment but neither may be the clinician in charge of the proposed treatment or the responsible medical officer. | 12.9 – 12.11<br>12.15<br>14.4 |
| **Tribunal** | The Mental Health Review Tribunal called in the Code 'the Tribunal' was established under section 5 of the Act. This is a judicial body which has the power to discharge patients from detention, community treatment orders, and can conditionally discharge those under restriction orders. | 6.16 – 6.19<br>13.18<br>13.48<br>13.52<br>Appendix III |
| **Voluntary patient** | Someone who is being treated for a mental disorder and who is not detained under the Act. | 10.5 – 10.14 |

[3]Starts from date of the relevant order or direction under Part III (instead of date of admission)

# APPENDIX II: SUMMARY OF MENTAL HEALTH ACT DETENTION SECTIONS

This appendix sets out the main sections of the Mental Health Act that concern detention of a patient. It summarises which professionals can make the application, the duration of detention, the conditions relating to renewal of the section and who is responsible for discharging the patient from the section.

| SECTION MHA | RECOMMENDATIONS | APPLICATION | DURATION | RENEWALS | DISCHARGE |
|---|---|---|---|---|---|
| **s.13** | 1 medical practitioner | MWO/NR/Police | 72 hours | No | RMO |
| **s.7(3B)** | N/A | Nurse | 3 hours | No | RMO |
| **s.7(3A)** | N/A | RMO or deputy | 72 hours | No | RMO |
| **s.14** | N/A | RMO or deputy | 3 days | No | RMO |
| **s.9** | 2 medical practitioners (1 consultant psychiatrist) | MWO/NR | 28 days | No | RMO/CoP/ MHRT |
| **s.10** | 2 medical practitioners (see Appx III) | MWO/NR | 1 year | s.22 | RMO/NR/ MHRT |
| **s.33** | 2 medical practitioners (1 s.12) | Magistrate or Puisne Judge | 1 year | s.221 | RMO/MHRT |
| **s.33/38** | 2 medical practitioners (1 s.12 + oral evidence) | Puisne Judge | s.38 can be either time limited or without limit | Not needed unless s.38 is time limited then reverts to s.33 above [s.38(5)] | Minister/ MHRT |
| **s.40(1)** | 2 medical practitioners (1 s.12) | Magistrate | Unlimited until case disposed of by Supreme Court | No | Minister/ MHRT |
| **s.43(1)** | Puisne Judge (via jury) | Governor and Advisory Committee on the Prerogative of Mercy | Unlimited | No | Minister/ MHRT |
| **s.44** | 2 medical practitioners (1 s.12) | Minister | 1 year2 | s.221,3 | RMO/MHRT |
| **s.44/45** | 2 medical practitioners (1 s.12) | Minister | Unlimited | No4 | Minister/ MHRT |

[4]Following case being disposed of by court
[5]If no longer prisoner (case dismissed, sentence expired) and remains in hospital [referred to as 'notional 33']
[6]If no longer a prisoner, section 45 'drops away' and 44 remains as 'notional 33'

| SECTION MHA | RECOMMENDATIONS | APPLICATION | DURATION | RENEWALS | DISCHARGE |
|---|---|---|---|---|---|
| s.71(1) | N/A (but medical practitioner and MWO must attend assessment) | MWO with Magistrate issued warrant | 72 hours | No | RMO |
| s.71(2) | N/A (but medical practitioner/nurse/ MWO may attend assessment) | Police/Nurse/ MWO with Magistrate issued warrant | 72 hours | No | RMO |
| s.72 | N/A | Police | 72 hours | No | RMO |

## Abbreviations

**CoP:** Chief of Psychiatry

**MHRT:** Mental Health Review Tribunal

**Minister:** Minister of Health

**MWO:** Mental Welfare Officer

**NR:** Nearest Relative

**RMO:** Responsible Medical Officer

**s.12:** Section 12(2) Approved Doctor

# APPENDIX III: MEDICAL REQUIREMENTS FOR CIVIL DETENTION (S13, 9, 10)[7]

This appendix sets out the requirements of medical practitioners who are responsible for completing sections 13, 9 or 10.

## Section 9 and 10 Requirements

| ONE MEDICAL PRACTITIONER | OTHER MEDICAL PRACTITIONER |
|---|---|
| Consultant Psychiatrist (Section 9) or<br><br>Approved under section 12 (Section 10) | *If the first medical practitioner does not have previous acquaintance with the patient:*<br><br>If practicable, a medical practitioner who has previous acquaintance with the patient |
| | *Otherwise:*<br>Any medical practitioner |

At least one of the medical practitioners should, if practicable, have previous acquaintance with the patient. Preferably, this medical practitioner should have treated the patient personally. Case law indicates that previous acquaintance need not involve personal acquaintance, provided the medical practitioner in question has some knowledge of the patient and is not hearing about the patient for the first time. For example they may have attended a case conference or previously discussed the case with colleagues.

## Section 13 Requirements

The medical practitioner giving the recommendation does not have to be approved under section 12. If practicable, the medical practitioner should be one who has had previous acquaintance with the patient.

An emergency application can be used to detain patients in hospital for no more than 72 hours, unless during that period a valid second medical recommendation is received by the hospital managers.

The second medical recommendation will only be valid if the two recommendations together would be sufficient to support an ordinary application for admission for assessment under Section 9 (except for the fact that the second recommendation may well, by necessity, have been signed after the date on which the application was signed).

It is preferable that a medical practitioner who does not have previous acquaintance with the patient be a Consultant Psychiatrist or otherwise approved under section 12 of the Act. The Act requires that at least one of the medical practitioners must be so approved. Patients admitted under section 13 should be examined by an appropriate second medical practitioner as soon as possible to decide whether they should continue to be detained. If the medical practitioner making the recommendation for the section 13 application was not a Consultant Psychiatrist or medical practitioner otherwise approved under section 12, the Act requires the medical practitioner making the second recommendation to be so approved.[2]

[2]UK MHA Code of Practicep137; 15.13

# APPENDIX IV: APPEALS AND STATUTORY REFERRALS TO MHRT

This appendix sets out the responsibility for making appeals to the Mental Health Review Tribunal. It summarises whether the application can be made by the patient or the nearest relative (NR), who is required to make a referral, the relevant time period during which the application can be made, and the requirement for the Board to refer cases to the MHRT in the event that a patient has not already exercised their right to apply.

| SECTION MHA | WHO CAN APPLY? | WHO CAN MAKE A REFERRAL? | PERIOD WITHIN WHICH APPLICATION CAN BE MADE | REQUIREMENT FOR BOARD TO REFER |
|---|---|---|---|---|
| **s.9** | Patient | n/a | 1-14 days [s.61(2)(a)] | n/a |
| **s.10** | Patient/NR | Board | 1 day-6months [s.61(2)(b)] | 6 months5 [s.61B(1)] |
| **s.19** | NR | n/a | 1-28 days [s.61(2)(c)] | n/a |
| **s.22** | Patient/NR | Board | 1 day-6 months or 1 day to 12 months [s.61(2)(d)] | 2 years [s.61B(2)] |
| **s.27** | NR | n/a | 1-28 days [s.61(2)(c)] | n/a |
| **s.29** | NR | n/a | 1 day – 12 months and every 12 months thereafter [s.61(2)(e)] | n/a |
| **s.33** | Patient/NR | Board/Minister | 1 day-6 months, every 12 months thereafter [s.36(3), s.61C(1)] | 2 years [s.61B(2)] |
| **s.33/38** | Patient | Minister | 6-12 months, every 12 months thereafter [s.38A, s.39(7)] | 2 years [s.61E(2)] |
| **s.38(5)** | Patient | Minister | 1 day-6 months [s.61C(2)] | 2 years [s.61B(2)] |
| **s.40(1)** | Patient | Minister | 6-12 months, every 12 months thereafter [s.38A, s.39(7)] | 2 years [s.61E(2)] |
| **s.43(1)** | Patient | Minister | 1 day-6 months [s.61C(2)] | 2 years [s.61B(2)] |

| SECTION MHA | WHO CAN APPLY? | WHO CAN MAKE A REFERRAL? | PERIOD WITHIN WHICH APPLICATION CAN BE MADE | REQUIREMENT FOR BOARD TO REFER |
|---|---|---|---|---|
| s.44 | Patient | Minister | 1 day-6 months, every 12 months thereafter [s.36(3)] | 2 years [s.61B(2)] |
| s.44/45 | Patient | Minister | 6-12 months, every 12 months thereafter [s.38A, s.39(7)] | 2 years [s.61E(2)] |

The Minister may at any time refer the case of any detained patient to the Tribunal [s.61A, s.61E]

| SECTION MHA | WHO CAN APPLY? | WHO CAN MAKE A REFERRAL? | PERIOD WITHIN WHICH APPLICATION CAN BE MADE | REQUIREMENT FOR BOARD TO REFER |
|---|---|---|---|---|
| s.48A (CTO) | Patient/NR | n/a | 1 day-6 months [s.61(2)(b)] | n/a |
| s. 48F(2)(b)(CTO Renewal) | Patient/NR | n/a | 1 day-6 months or 1 day to 12 months [s.61(2)(ba)] | n/a |
| s.48M (CTO Revocation) | Patient/NR | n/a | 1 day-6 months [s.61(2)(b)] | n/a |

# APPENDIX V: FORMS TO BE USED WHEN IMPLEMENTING THE MENTAL HEALTH ACT

These 3 sets of forms are used by the appropriate clinicians and managers in the implementation of the Mental Health Act. Forms can be obtained by calling the Mid-Atlantic Wellness Institute at (441) 236-3770.

## Hospital forms

| FORM NUMBER | TITLE OF FORM | TO BE COMPLETED BY: | RELATES TO MHA SECTION: |
|---|---|---|---|
| HO1 | Joint Medical Recommendation - Admission for Assessment | 2 Medical Practitioners | 9 |
| HO2 | Emergency Holding Power (nurses) | RMN | 7 (3b) |
| HO3 | Emergency Holding Power (physicians) – 72 hours | Medical Practitioner | 7 (3a) |
| HO4 | Emergency Holding Power (physicians) – 3 days | Medical Practitioners | 14(2) |
| HO5 | Application by Approved MWO - Admission for Assessment | MWO | 9 |
| HO6 | Medical Recommendation – Admission for Assessment | Medical Practitioner | 9 |
| HO7 | Application by MWO – Admission for Treatment | MWO | 10 |
| HO8 | Application by Nearest Relative – Admission for Treatment | NR | 10 |
| HO9 | Medical Recommendation – Admission for Treatment | Medical Practitioner | 10 |
| HO10 | Joint Medical Recommendation – Admission for Treatment | 2 Medical Practitioners | 10 |
| HO11 | Emergency Application for Assessment (MWO, Police or Nearest Relative) | MWO, Police, Nearest Relative | 13 |
| HO12 | Reclassification of Patient Detained for Treatment | RMO | 19 |
| HO13 | Medical Recommendation – Emergency Admission for Assessment | Medical Practitioners | 13 |
| HO14 | Renewal of Authority for Detention | RMO | 22 |
| HO15 | Authority For Detention After Absence Without Leave | Unspecified but should be RMO & HM | 21 |

## Community Treatment Orders

| FORM NUMBER | TITLE OF FORM | TO BE COMPLETED BY: | RELATES TO MHA SECTION: |
|---|---|---|---|
| CTO1 | Community Treatment Order | RMO & MWO | 48A |
| CTO2 | Variation of Conditions of a Community Treatment Order | RMO | 48C(3) |
| CTO3 | Extension of Community Treatment Period | RMO & MWO | 48F |

| FORM NUMBER | TITLE OF FORM | TO BE COMPLETED BY: | RELATES TO MHA SECTION: |
| --- | --- | --- | --- |
| **CTO4** | Authority for Community Treatment after Absence without Leave for more than 28 days | RMO | 48L |
| **CTO5** | Notice of Recall to Hospital | RMO | 48H |
| **CTO6** | Record of Patient's Detention in Hospital following Recall | HM | 48H |
| **CTO7** | Revocation of a Community Treatment Order | RMO & MWO | 48M |
| **CTO8** | Discharge by the RMO or the Chief of Psychiatry or Nearest Relative | RMO or CoPsych or NR | 26 |

## Consent to Treatment

| FORM NUMBER | TITLE OF FORM | TO BE COMPLETED BY: | RELATES TO MHA SECTION: |
| --- | --- | --- | --- |
| **CTT1** | Certificate of Consent to Treatment Second Opinion e.g. Neurosurgery for mental disorder | SOAD, RMN, another professional | 48P |
| **CTT2** | Certificate of Consent to Treatment | RMO or SOAD | 48Q(2)(a) |
| **CTT3** | Certificate of Second Opinion | SOAD | 48Q(2)(b) |
| **CTT4** | Certificate of Consent to Treatment – ECT | RMO or SOAD | 48R |
| **CTT5** | Certificate of Second Opinion – ECT (patient unable to consent) | SOAD, RMN, another professional | 48R (2) (b) |
| **CTT6** | Certificate of Treatment – SOAD CTO conditions | SOAD, RMN, another professional | 48.1B(3) |
| **CTT7** | RMO Part IIIC Certificate – Consent to treatment for Community Patient | RMO | Part IIIC |

## Glossary

**Medical Practitioner** Physician
**RMN** Registered Mental Nurse
**SOAD** Second Opinion Approved Doctor
**MWO** Mental Welfare Officer
**NR** Nearest Relative
**RMO** Responsible Medical Officer
**CoPsych** Chief of Psychiatry
**HM** Hospital Managers