

Mental Health Jersey Law 201-
Response to stakeholder consultation

Section 1: Introduction

- 1 There has been frequent criticism directed at the Mental Health (Jersey) Law 1969 (“the 1969 Law”) and the Criminal Justice (Insane Persons) (Jersey) Law 1964 (“the 1964 Law”). It is recognised that the 1969 Law is in need of reform to reflect modern approaches to the diagnosis and treatment of persons with a mental disorder.
- 2 Furthermore, the 1969 and 1964 Laws also cause difficulty for the courts and criminal justice system in general in dealing with cases involving people who are accused of offending who have or may have a mental disorder. These Laws do not provide the courts with appropriate powers to order the assessment or treatment of someone appearing before them.
- 3 A project team composed of officials in the Health and Social Services Department, Law Officers’ Department and Chief Minister’s Department have been working to develop a comprehensive replacement for the 1969 and 1964 Laws. The project team were initially supported by their counterparts in Guernsey, where a comprehensive new Mental Health Law was recently brought into force, to identify how we can draw on Guernsey’s expertise and experience.
- 4 In addition to the introduction of a new mental health law (the “new Law”) the project team have simultaneously been developing a new capacity and self-determination law. The outcome of that consultation process can be found on the States of Jersey website.
- 5 The consultation process for the new Law consisted of 4 phases:
 - Key stakeholder expert dialogue
 - Law drafting
 - Public consultation of the new Law
 - Review of consultation feedback

Section 2: Key Stakeholder Expert Dialogue

- 6 On the 25th September 2014 an expert dialogue day was held at Jersey Hospice. There were 41 attendees representing:
- Carer and Service Users
 - Voluntary and community sector
 - Safeguarding Partnership Board
 - H&SSD
 - Primary Care
 - States of Jersey Police
 - HMP La Moye
 - The Magistrates Court
 - Judicial Greffe
 - Mental Health review tribunal
 - Viscounts Department
 - Law Society
- 7 Prior to the expert dialogue day those attending were forwarded two documents, “Mental Health law Expert Dialogue Group - Background Reading” and “Proposed mental health Law Expert Dialogue – Workbook”. The attendees were given the opportunity to use the workbook prior to and during the workshop as a means to respond to the broad policy proposition. The completed responses helped shape the final law draft which was published for full consultation in July 2015.
- 8 At the expert dialogue day workshop participants were divided into 5 groups each with a facilitator. The workshop consisted of three sessions, each of which was preceded with a short presentation focussing on different parts of the proposed new legislation which were; *‘Types of Detention’*, *‘Police Powers and the role of the Courts’* and *‘Safeguards and Miscellaneous Provisions’*. Each of the three topics was discussed in detail within the groups followed by feedback to the larger group. The key feedback issues were captured by a note taker and notes of the workshop including the feedback was circulated to the attendees in November.
- 9 The broad issues raised at the workshop and from the 5 returned workbook responses are highlighted below:

Question1: Do we have the right people undertaking the appropriate duties?

- 10 There was support for broadening the scope of practitioners that could act as a Duly Authorised Officer (DAO) (officers appointed by the Minister to make an application for detention) to include disciplines other than social workers whilst being cognisant of not introducing an imbalance between professional disciplines.
- 11 The training requirements for both the DAO and Approved Medical Practitioner (AMP) (A doctor with sufficient experience and training in the field of mental health and in the operation of legislation relating to mental health to be approved by the Minister to complete medical recommendations for detention) was seen as important and whilst there could be some benefit on being based on standards employed in England any training and competency requirements must ultimately be tailored to Jersey's needs.
- 12 Some attendees questioned how the role of AMPs in making medical recommendations for detention might impact on the doctor/patient relationship.
- 13 It was suggested that a Responsible Medical Officer (RMO) (the doctor with the overall responsibility for the treatment of the patient whilst detained) would be preferable in Jersey to a *Responsible Clinician*, the definition used in equivalent Scottish, English and Welsh legislation and that the role should remain with a senior psychiatrist for assessment and treatment detentions.
- 14 It was emphasised that the new Law needs to be clear in the terminology used for describing all the intended roles and a code of practice should clearly define the roles and responsibilities within the new Law.
- 15 It was suggested that there should be a pool of doctors trained to be equivalent to the Section 12 approved practitioners under the Mental Health Act 1983 ("MHA 1983"). Furthermore, the two medical recommendations required for exercising some compulsory powers shouldn't come from within the same clinical team. The question was raised as to the second medical recommendation coming from any registered medical practitioner, not just the patient's GP as a patient's GP might not always be available.

Question 2: Do we have sufficient powers and procedures within the proposals to meet the needs of an island community?

Definitions

- 16 It was considered important that the new Law provides an appropriate definition of 'mental disorder' and, generally, the new Law should provide clarity around terms used e.g. assessment/assessment order; treatment/treatment order.

Approved Establishments

- 17 Some attendees discussed proposals surrounding approved establishments. It was thought that the new Law should be innovative as regards such establishments but there was a concern as to who would be responsible for regulating their provision. There was a suggestion that the Health and Social Care Commission (the "Care Commission"), established under the Regulation of Care (Jersey) Law 2014 could have a role to play here.

Nurses Holding Powers

- 18 It was thought that there was a lack of clarity surrounding proposals for nurses holding powers and the use of the word 'voluntary' regarding holding powers was queried with one participant asking if 'voluntary' covered every medical centre.

Assessment and Treatment Authorisations

- 19 There was suggestion that proposals for assessment and treatment authorisations required further clarity. There was some concern regarding appeal periods relating to an assessment authorisation and an opinion that there should be a right of appeal from the outset, i.e. within the first 14 days of the authorisation and a review before the Tribunal within 7 days of making an appeal.
- 20 If an RMO is satisfied that a patient is no longer suffering with a mental disorder or that it is not necessary in the interest of the patient or others to continue the detention, it was suggested that the patient 'must' be discharged.
- 21 It was stated that the new Law must provide that decisions relating to detention authorisations are open to appeal.

Emergency authorisations

- 22 There was a suggestion that the exercise of emergency powers should require more than one medical recommendation. There was also a concern that the power to detain a patient for 72 hours under an emergency authorisation was too long and some attendees suggested it should be reduced from 72 hours to 12-24 hours. However, an opposing view to this was that while a short period of detention would be best practice there would be circumstances in which a longer period of detention prior to assessment was necessary. From a policy perspective the new Law had to provide sufficient flexibility to allow for circumstantial and social change, therefore 72 hours was felt to be most appropriate.

After-Care Provision

- 23 It was suggested that the new Law should include provision for after-care rights (look to section 117 MHA 1983). However, an alternative view was that it is important not to set up any perverse incentives. For example, in the UK s.117 MHA 1983 provides that social services provide free aftercare to anyone who has been detained for treatment compared with social care that is otherwise charged for. However, in Jersey the Minister has responsibility for both Health and Social Services and will have the power within the new Law to provide care and treatment to people suffering a mental disorder.

Intoxicated Persons

- 24 The question of the assessment of intoxicated persons was raised and what powers would there be to detain someone who is intoxicated in order to assess them as well as how long should be given for a person to sober up prior to assessment?

Treatment

- 25 The definition of what constitutes treatment needs to be clearly defined within the new Law.

Question 3: Will the implementation of Community Treatment Orders (CTOs) provide real alternatives to hospital based treatment for Jersey residents?

26 There was a mixed reception to the idea of CTOs in Jersey. Some welcomed their inclusion but others queried the success and benefit of CTOs. Many attendees wanted a better understanding of the application of CTOs in the UK and wanted to see evidence as to their effectiveness. There was a general sense that CTOs were not effective in the UK. Some attendees were clear that Jersey should not look to replicate CTOs but rather tailor a different form of community treatment specifically for Jersey's needs. It was felt that this was an opportunity for Jersey to be innovative in the new Law perhaps look to other jurisdictions, other than the UK to see what alternative community treatments are implemented. It was recognised that at present Article 20 of the MHL provides for leave of absence from hospital and has been used to secure CTO objectives. It was suggested that we look at tweaking Article 20 rather than introducing a new system.

27 However, if CTOs were to be introduced it was suggested:

- CTOs need to be set out clearly in the new Law and possibly include a statutory duty on service providers to co-operate.
- Clear guidance on implementing CTOs where the patient was also required to take prescription medicine.
- An RMO should remain responsible for someone subject to CTOs as the needs surrounding their imposition will be complex.
- Clarity of who would be involved in the renewal process for CTOs
- It was also considered important to keep the use of any form of CTOs under review to protect against overuse.
- There will need to be clarity as to who has responsibility ensuring the patient subject to a CTO returns to the approved establishment and if someone subject to a CTO in a public place can be subject to the equivalent of the current Article 47 power (powers for a Police officer to remove to a place of safety).
- A code of practice to support any CTO provisions would be essential as would be multi-agency protocols and policies.

Question 4: Where should places of safety be provided?

- 28 There was a view that there should be flexibility in the new Law as to the designation of places of safety. Jersey should learn from Guernsey which has several places of safety specified under its legislation.
- 29 Reference was made to section 135 of the MHA 1983 for a suggested expansive provision regarding places of safety (the MHA 1983 gives 5 possible categories of a place of safety). Jersey could possibly include residential and care homes.
- 30 It was generally thought that A&E should be the initial place of safety to allow a medical assessment to rule out non-mental health causes for the need of immediate care and control.
- 31 Some attendees queried whether it would be possible for a private residence to be a place of safety. This might allow resources to be taken to the patient rather than taking the patient elsewhere.
- 32 There was discussion about having a crisis centre in Jersey, i.e. to enable access to a centre 24/7, for short-term use.
- 33 The specific needs of a place of safety for children were raised. It was felt that generally, the appropriateness of a place of safety should depend on risk assessment, prevention of harm and the particular needs of the patient in question. It was suggested that the new Law needs to include the grounds for determining where a person is taken, i.e. to which place of safety, and, when a person is taken to a place of safety, what would they be assessed for.
- 34 Any proposals around places of safety should be cognisant that there is a stigma surrounding certain places earmarked as places of safety e.g. mental health facility or the police station.
- 35 The issue of using the police station as a place of safety raised significant concern with some of the attendees. A number of guidelines from the UK regarding section 136 MHA 1983 (equivalent to the current Article 47 of the 1969 Law) states the use of a police station as a

place of safety should only be used in exceptional circumstances. However, a quote from HMCI (2013): *“A Criminal Use of Police Cells?”* stated that in England police custody was still being used as a primary or secondary place of safety and that when the reasons for the use of police cells were recorded they often referenced insufficient staff or lack of beds in health facilities or that the person had consumed alcohol.

- 36 Once in a place of safety, will the new Law allow for the person to be moved under the same powers or will a further order need to be made?

Conveyance

- 37 It was suggested that there needs to be a greater understanding around the types of conveyance methods and resources available. There were also issues around the stigma of being conveyed by a particular mode of transport e.g. police van/ambulance. Some attendees thought that an ambulance was not a suitable form of conveyance in some cases, as it would be full of equipment that might be considered harmful or dangerous to the occupants.
- 38 Consideration needs to be given to the conveyance of non-risk persons, young people, vulnerable and/or elderly and it was proposed that the new Law should include provision for DAOs to specify the appropriate method of conveyance for a patient based on an individual risk assessment.
- 39 Some attendees stated there would need to be clear inter-agency protocols for decision making around which service will provide conveyance. Support Services were generally happy with proposals for conveyance, but noted that in practice the police rather than the ambulance service would be used for conveyance. It has also been raised that post court conveyance to hospital should be considered.
- 40 The question as to the powers of the police to remove someone in need of mental health assistance from their own home to a place of safety for assessment was raised.

Question 5: Is there a sufficient range of court powers to enable access to treatment?

- 41 Some attendees thought that the proposals surrounding appeals needed to be clarified, e.g. who makes representations on behalf of a patient and what role would mental health advocates play.
- 42 It was suggested that Jurats and magistrates might benefit from having mental health law training.
- 43 There was some discussion regarding the benefits of having a hybrid order available to the courts, as in England and Wales. This would enable the court to impose a prison sentence but then to make an immediate hospital transfer order. The person could then go directly for treatment within a hospital, but be liable to be sent to prison afterwards without the need for the persons to be subject to a hospital order with restrictions (which would have an indefinite duration and would need to be made by the Royal Court after satisfying a high threshold test).
- 44 As regards to in-patient remand, there was an opinion that a maximum of 3 periods of remand of 28 days would be preferable to reduce the length of time prior to the case being heard in court.
- 45 With regards to a restriction order, it was queried for what purpose reports are made and to whom.
- 46 It was suggested that the new Law needed to include an appropriate mechanism for committal to the Royal Court from the magistrates' or children's courts.
- 47 There was recognition that there were particular difficulties in dealing with people held on remand and that there needed to be appropriate mechanisms for remand prisoners to access forensic services in the UK, though there are challenges in doing so given the fact that UK legislation does not facilitate this where a person is subject to MHL remand orders.

Question 6: Which courts should have which powers?

- 48 There was general support, including from those working in the magistrates' and Royal Courts, for the principle that it should be possible for the magistrates' court and youth court

to decide matters regarding fitness to plead and insanity that would otherwise fall within their jurisdiction. However, it was recognised that appropriate provision would be required for these cases to be transferred from those courts to the Royal Court for the appropriate order to be made (i.e. a restriction order) in some cases.

Question 7: What are your comments on the introduction of Second Opinion Approved Doctors with regard to overriding consent?

- 49 There was agreement that Jersey should introduce Second Opinion Approved Doctors (SOADs). A SOAD is a psychiatrist from outside Jersey who is brought in to review the treatment of people subject to treatment orders. However, there were some concerns that SOADs could never really be independent of HSSD.
- 50 It was recognised that the Care Commission would perform a role with regard to regulating care services provided by HSSD and that this would, in the longer term, help to ensure that appropriate governance systems are in place.

Question 8: Will the proposals to provide access to mental health tribunals increase the level of safeguards to people under the new Law?

- 51 There was general agreement that proposals to provide access to the Mental Health Review Tribunal would improve safeguards under the new Law. Specifying timescales applicable to Tribunal procedures would act as an important safeguard. There was some suggestion that the new Law should include a requirement for automatic reviews of the decision to detain a person every 6 months.
- 52 It was suggested there should be a code of practice around Tribunals, in addition to the new Law in general. We were asked to consider clarity of the roles and responsibilities of Tribunal members. It was thought that the medical member should have mental health law training.
- 53 There was discussion with regard to the difficulty in recruiting and retaining medical members for the tribunal, despite repeated requests and recruitment this is a major factor limiting the speed with which a tribunal can be convened.

54 It was thought that an appeal to the Tribunal regarding a treatment order should be heard within 5-8 weeks.

Question 9: Do you agree with the proposals for access to legal advice and advocacy for people who are detained?

55 It was thought that the role and functions of both legal advocates and mental health advocates should be given a statutory basis, and that such representatives must be appropriately trained.

56 There was a suggestion that there should be an automatic carers needs assessments and the automatic right to have services provided.

57 In this section of feedback some attendees raised points concerning the approach the new Law would take toward children - there was reference in the workbook to "Parental responsibility" and some attendees raised questions regarding the meaning of this. In response it was noted that children over 16 years of age may be expected to have capacity to consent to medical treatment in their own right which may trump 'parental responsibility'.

58 A number of attendees described the 16-18 age range as being particularly complicated age and provisions in the new Law needed to be clear regarding young people in this age range.

59 It was emphasised that the new law would need to dovetail with the Children's (Jersey) Law 2002 and engage Children's Services.

60 The question was posed regarding children and young people and parental consent / lack of consent. It was suggested there may need to be additional safeguards for children and young people including more frequent reviews. The need for possible referral to the Royal Court for judgement relating to children or young people who refuse treatment was raised.

Section 3: Law Drafting

61 Following the expert dialogue process and being cognisant of the comments and feedback received the policy lead with the law officers and officers from the Chief Ministers

Department prepared law drafting instructions. A law draftsman was appointed and over the next six months a final draft of the new Law was prepared for publication and public consultation.

- 62 During the law drafting process the policy lead and law officers met with the political steering group to keep them updated of the progress and to receive comment and answer questions. The political steering group consisted of the Health and Social Services Minister, Treasury and Resources Minister, Housing Minister, Home Affairs Minister, External Relations Minister and the Assistant Chief Minister.
- 63 The policy team met with the Health and Social Security Scrutiny panel to give them an overview of the proposed new law and to enable them to discuss the broad issues and prepare for the detailed scrutiny process that will follow lodging of the new Law.
- 64 A presentation to members of the Royal Court including the Bailiff and Jurats regarding the proposed powers of the Royal Court within the new law took place during this period which provided some useful observations specifically relating to the incorporating the current Criminal Justice (Insane Persons) (Jersey) Law 1964 into the new Law.

Section 4: Public Consultation of the Draft Law.

- 65 The draft law was published on the States of Jersey government consultation website on the 3rd July 2014. A news release was circulated asking Islanders for their views on the new Law. The consultation process ran until the 31st of August 2015, however, there were some late respondents that have been included in the consultation feedback.
- 66 A supporting document was published alongside the draft law giving an overview of why a new Law is required and the areas it intends to cover. This document was written in non-legal / non-medical language and covered the key changes in the new Law which include new definitions and roles, patients representatives, compulsory powers, leave of absence changes, consent to treatment and safeguards on compulsory treatment, place of safety, replacement of the Criminal Justice (Insane Persons) (Jersey) Law 1964, criminal offences, curatorship and code of practice.

- 67 On the 15th July 2015 the expert dialogue group were invited to attend a presentation at the Haliwell Theatre at the general hospital. The presentation gave an overview of the new Law, focusing on the new safeguards and criminal justice provisions.
- 68 At the end of the consultation process a total of 7 written responses had been received from charitable and voluntary organisations, States of Jersey departments', law firms and individual members of the public. Although there were not vast numbers of responses the quality of feedback was excellent and has been most valuable in shaping the final law that will be lodged before the States.
- 69 Of note was a detailed response from MIND Jersey that covered 35 pages and 156 comments. To ensure the issues they had raised were appropriately addressed the policy lead and law officers met with MIND Jersey representatives to discuss the issues raised and clarify rationale of policy responses.
- 70 Below the key comments and issues are recorded under their respective headings within the new Law followed by a policy and legal response.

PART 1

INTERPRETATION, APPLICATION AND OTHER GENERAL PROVISIONS

- 71 **Comment:** It was suggested that the term 'liable to be detained' required definition.

Response:

The term "liable to be detained" rather than simply "detained" is used to reflect that the new Law applies to a person who is on leave of absence or absent without leave. We don't agree that the phrase is inherently unclear to require definition in the primary legislation.

Amendment: None

- 72 **Comment:** Concern was raised as to the use of the word 'patient' throughout the new Law for someone whom, "in common parlance", would not be considered to be a patient if they were in the community.

Response:

It is quite proper to refer to people who may have a medical condition or require assessment for a condition to be described as a 'Patient', it is not a pejorative term; for example, a member of the general public who attends a general practitioner is regarded as that GP's patient.

Amendment: None

73 **Comment:** Concern was expressed regarding the roles of "approved practitioner" and "responsible medical officer", and it was suggested the two differing roles were unnecessary and confusing and that it may be more straightforward if all RMO's also met the criteria of being an approved practitioner.

Response:

Responsible Medical Officers (RMOs) will have overall responsibility for overseeing a patient's care and detention under the new Law and will also meet the criteria of Approved Practitioners (APs). However, the RMO will be a registered medical practitioner trained in psychiatry and on the specialist register. They will therefore be a senior doctor in psychiatry.

The AP role is substantially different. The primary role of APs will be to provide medical recommendations in connection with an application to detain a person for assessment or treatment. It is important that such recommendations come from a registered medical practitioner with some training and expertise in the field of mental health and mental health law but they do not need to be trained to the same standard as RMOs. APs are equivalent to Section 12 Approved Doctors in the MHA 1983.

Amendment: None

74 **Comment:** With regard to the Annual Report to be produced by the Mental Health Law Administrator, it was suggested that the Law, rather than the Code of Practice, should specify what this report must cover.

Response:

The annual report to be produced by the administrator, under Article 4(2) of the new Law, is to contain such information as the Minister directs; the contents of the report will not be prescribed by Code of Practice. It is appropriate for the Minister to direct the administrator to report on those matters the Minister feels will enable him to properly evaluate the administration of the MHL. There is nothing to be gained by fixing those matters in the

legislation; to do so is too rigid an approach and would deny the Minister the scope to require reports on specific matters which may vary from year to year.

Amendment: None

75 **Comment:** There was concern that the term Authorised Officers could be distressing to some patients and may be misunderstood as representatives of the police service.

Response:

The term 'authorised officer' is a term that is used within the new Law simply to delineate a particular role authorised by the Minister. The term is appropriate as it reflects that the person is both authorised by the Minister and an officer of the Health and Social Services Department. The term 'authorised officer' is one which appears frequently on the statute book in Jersey.

Amendment: None

76 **Comment:** The inclusion of a range of professionals who can be 'Authorised Officers' rather than only qualified social workers was questioned citing the need for a 'social welfare' model of the social worker to counterbalance the 'medical model' of the doctors recommendations. Furthermore, it was suggested that experienced nurses and psychologists do not work to the social welfare model.

Response:

The 1969 Law does not specify the professional status of the *Duly Authorised Officer* and allows the Minister to identify who should be appointed. The amended MHA 1983 has moved away from 'approved social workers' to 'approved mental health practitioners' allowing professionals other than social workers to train into this role. Limiting Approved Officer status to one professional group has proved problematic, the key will be the quality of the training provided for our Approved Officers.

Amendment: None

PART 2:

REPRESENTATION

77 **Comment:** As the patient will have the right to nominate their own representative why should it be presumed that the 'nearest relative' is the representative?

Response:

There has been confusion regarding the use of the terms 'representative' and 'nearest relative'. To address this we have withdrawn the term 'representative' and replaced it with 'nearest person'. All patients will have a 'nearest person' who will have rights and responsibilities within the new Law to act on behalf of the patient. To ensure all detained patients have a 'nearest person' the default role will fall to the 'nearest relative' until the patient or the court nominates a 'nearest person'.

Amendment: Article 7, Nearest person in relation to a patient, now reads:

(1) In relation to every patient there shall be a natural person who fulfils the role of the patient's nearest person for the purposes of this Law.

(2) A patient's nearest relative (as determined in accordance with Article 8 or 9) shall be that patient's nearest person, unless a nomination is made under Article 10 or an appointment is made under Article 11.

(3) The nearest person shall have all such rights and responsibilities as are conferred by this Law and in particular the right to act on behalf of the patient as further provided by Article 13.

(4) The role of a nearest person as defined by this Article is additional to, and does not derogate from, the role of an independent mental health advocate under Article 79.

78 **Comment:** Why are people living in the UK excluded from being a representative (now nearest person) when we have such good communication systems?

Response:

Whilst it is recognised that modern communications systems allow people direct access and could be utilised for representation this is often more challenging for people who have a mental disorder. We feel it is important that the nearest person has the opportunity to provide face to face support to the patient; the communication process when someone is distressed is more than a conversation.

Amendment: None

79 **Comment:** Why must a representative (now nearest person) carry out his or her responsibilities and functions in the manner which is in the patient's best interests as work carried out by the independent advocate is NOT to take a best interests view but to seek to

put over the patients case and let others (the decision makers) use the best interest's approach.

Response:

The role of the Independent Mental Health Advocate (IMHA) under the new Law is different to the role of the nearest person. The nearest person will normally be appointed precisely because of their relationship to the patient, either as nearest relative or because they are a person appointed by the patient themselves. They may also be appointed by the Minister or court, but again we expect that would usually be because they are an appropriate person to represent the patient's best interests. At the core of their role is deciding how to exercise the legal rights afforded to the nearest person in a way that will, in the nearest persons view, advance the patient's best interests, for example, it might not always mean that the nearest person applies for discharge of the detained patient, and we should not assume that because a nearest person doesn't apply for discharge they are not acting in the patient's best interests. This role is quite different to the role of the IMHA. The role of the IMHA is to seek to understand the point of view of the client and to advance that point of view most effectively to those responsible for making decisions in respect of a patient.

Amendments: None

80 **Comment:** We cannot see any proposal that gives the representative (now nearest person) power to object to guardianship.

Response:

We accept this comment

Amendment: we will remove Article 11(4)(c), allowing the nearest person the right to object to guardianship.

81 **Comment:** With regard to the rights of the representative to receive information as to a patients care and treatment there is nothing in the proposed law setting out by what criteria the RMO should exercise this judgement where the patient lacks capacity.

Response:

The RMO needs to consider the best interest of the patient who lacks capacity to disclose such details, this is one of the principles within the draft Capacity and Self-Determination (Jersey) Law (the "Capacity Law"). The duty of the RMO is clarified in the amendment below.

Amendment:

13 Rights of nearest person to receive information as to patient's care or treatment

(1) Unless one of the conditions in paragraph (3) is satisfied –

(a) the responsible medical officer must provide the nearest person with details (in writing, where reasonably practicable) of any care or treatment proposed in respect of the patient;

(b) the nearest person is entitled to make representations to the responsible medical officer about such proposals; and

(c) the responsible medical officer must, in prescribing or administering care or treatment to the patient, have regard to any representations made under sub-paragraph (b).

(2) In particular and without derogation from the general requirement in paragraph (1)(a), the responsible medical officer must inform the nearest person –

(a) where a treatment authorization is renewed under Article 22, of the reasons for renewal mentioned in Article 22(4)(a);

(b) of any leave of absence granted under Article 24, and of any conditions (including treatment conditions) attaching to such leave of absence;

(c) where a plan of treatment is formulated for the purposes of Part 6, of the contents of the plan and of any significant changes which may be made to the plan from time to time;

(d) of any proposed treatment for which a certificate would be required from a SOAD under Article 40 or 41; and

(e) of such other details of a kind which may be specified in a code of practice.

(3) The conditions mentioned in paragraph (1) are that –

(a) where the patient has capacity to do so, the patient has refused to give consent to the disclosure to the nearest person of the details of proposed care or treatment (whether generally or in a particular instance);

(b) where the patient lacks capacity to give or refuse consent, the responsible medical officer considers that it is not in the patient's best interests to disclose such details; or

(c) in any other case, the responsible medical officer considers that disclosure of such details would be likely to cause serious harm to the patient or to any other person.

(4) Where one of the conditions in paragraph (3) is satisfied, the responsible medical officer shall inform the nearest person (in writing, where reasonably practicable) that details under paragraph (1) are not provided for that reason, identifying the particular condition which is satisfied in the case.

(5) A nearest person is entitled to be informed of any proposed transfer of a patient under Article 26, and of the date of such transfer.

(6) This Article applies in addition to, and not in derogation from, any rights otherwise conferred on a nearest person by this Law or any other enactment.

PART 3

APPROVED ESTABLISHMENTS: PROCEDURES FOR ADMISSION ETC.

82 **Comment:** Article 14 "*Voluntary admissions*" clearly and quite correctly states that this can only apply where a person has capacity to consent. Therefore there needs to be a statutory requirement that the RMO carries out a capacity assessment involving formal documentation before a voluntary admission can take place.

Response:

There is no need for such a statutory requirement. This will be a matter of practice and will be best dealt with in CoP (Code of Practice). The first Principle of the Capacity Law is that a person must be assumed to have capacity.**Amendment: None**

83 **Comment:** Emergency Admissions under Article 15 allows for an authorization to run for a period of 72 hours. It was suggested that this period of time should be shorter; one response suggested 4-6 hours whilst another suggested 24 hours.

Response:

This period is equivalent to that in the MHA 1983 section 4(4). The length of the period of 72 hours is appropriate as it enables sufficient time for an emergency assessment of the person to be carried out. It is accepted that, where possible, the length of time someone is subject to Article 15 should be as short as possible and guidance will be provided within the CoP.

Amendment: None

84 **Comment:** Detention by a Nurse using Article 17 (2) states that *'The nurse may make a record'*. It was stated that it should read the nurse **'must'** make a record.

Response:

We are in agreement with this comment. Such records should be mandatory. The draft will be amended accordingly.

Amendment: Article 17 (2) (a) now reads 'the nurse **must** make a record'

85 **Comment:** Detention by a Nurse using Article 17 (2) states that the nurses holding powers allows for the patient to be detained for a period of no longer than 6 hours beginning at the time the record is made. The question was asked as to why it should take up to 6 hours for a doctor to arrive on the ward to assess the patient for either discharge or a further period of detention.

Response:

In most circumstances a doctor will be able to respond in a shorter time frame than 6 hours, however, whether they are on-call or carrying out their regular duties such as out-patient clinics or assessments of other patients up to 6 hours may be required. The CoP will give guidance on ensuring the assessment from the doctor is completed as swiftly as practicable.

Amendment: None

86 **Comment:** A point was raised that the Effect of Admission application, Article 20 (1) (b) appears to suggest that the patient can be held for a week without the ability to appeal, and stated that this would be unlawful.

Response:

It is agreed that clarity was required.

Amendment:

Article 20 provides for the effect of an application for the admission of a person to an approved establishment for either assessment or treatment. Appeals to the Mental Health Review Tribunal are described in Schedule 1, Part 2 within the table. For patients detained for assessment it states they are able to make an application to the tribunal within the first *'14 days*

*beginning with the day on which notice is given under Article 20(2) that the patient is **admitted** to an approved establishment'. For patients detained for treatment it states they are able to make an application to the tribunal '6 months beginning with the day on which notice is given under Article 20(2) that the patient is admitted to an approved establishment'.*

87 **Comment:** Article 23, Rectification of applications and medical recommendations, raised concerns. It was stated that a detention would be unlawful if the application or recommendation contained an error of defect.

Response:

Powers to rectify applications are found in Article 13 of the 1969 Law and Section 15 of the MHA 1983. These powers and the power in Article 23 of the new Law reflect that inevitably, in view of the nature of the information that is required to support an application and circumstances in which it must be provided (often at short notice and with substantial urgency) incorrect information may be included on a form e.g. the identity of the patient's nearest relative. It is important that errors or defects are identified and addressed so as to avoid incorrect information being repeated. The power to rectify in Article 23 is intended to ensure that the authority on which a patient is detained is based on accurate information, without jeopardising the care and treatment of patients by requiring that they be unnecessarily discharged. The Article 23 power is exercisable only with the consent of the Minister and is not intended to enable serious errors or defects to be covered up.

We do not agree that the identification of an inaccuracy or defect in the admission paperwork for an individual will necessarily render the person's detention unlawful as the question presumes. In this regard we note the decision of the European Court of Human Rights in *Mooren v Germany* (2010) 50 EH.R.R.23, where it was held that defects in a detention order did not render the underlying detention unlawful for the purposes of Article 5(1) of the ECHR unless they amounted to "*a gross and obvious irregularity*". The Minister's control on such rectifications will also enable him to evaluate the performance of those involved in applications or medical recommendations, and to spot any repeated defects or errors. The Minister's principle duty under the MHL is for the care and treatment of persons and he must also act in a manner that is compatible with the ECHR, in particular Article 5 (right to liberty).

Without an Article 23 power, where there is any defect or error, of whatever degree, the authority to detain a person would cease as the application would not be deemed to have been made in accordance with the law. A fresh application would then have to be made. That approach is arbitrary and inflexible in view of the purposes of the new Law. It would jeopardise the care and treatment of persons and may have serious consequences for the patient and others.

Amendment: None

88 **Comment:** With regard to Leave of absence from approved establishment, Article 24 (2)(b), the question was asked if this means that in some circumstances the Minister could overrule the RMO?

Response:

Article 24 (2) (b) (now Article 24(2)(a)) does not provide the power for the Minister to overrule the RMO. Article 24 (2) (b) provides the Minister with the power to prescribe, by Order, certain terms and conditions which **must** be applied in the leave arrangements of all patients under Article 24. It is envisaged that these terms and conditions will be of a general nature and will be suitable to apply in the case of all patients granted leave under Article 24.

Amendment: Article 24 (4) will now include the words ‘the responsible medical officer must give notice in writing to the Minister of the grant of leave and the period for which, and the conditions (if any) upon which leave is granted’.

89 **Comment:** Article 24 (3) (c) led to concern with the use of “indefinitely”, the question was asked does this mean that whilst on leave the patient remains subject to treatment powers?

Response:

Use of ‘indefinitely’ is intended to indicate that a person may remain on leave without limit of time for so long as they remain ‘liable to be detained for treatment’. While on leave, the patient would remain subject to treatment powers within Article 24(7) which provides that a patient absent on leave may be recalled to the approved establishment, where that patient’s treatment could continue. Whilst on leave the patient maintains the right to appeal to the Mental Health Review Tribunal.

Amendment: None

90 **Comment:** It was noted that the draft law does not provide an equivalent MHA 1983 section 117 aftercare.

Response:

The duty to provide aftercare in section 117 of the MHA 1983 is a device of English Law to ensure that aftercare services are provided to patients on their discharge from compulsory detention for treatment and to ascribe the cost of providing that care, for free, to particular public bodies. In England the responsibility for the provision of social care does not sit with the health minister whereas in Jersey the Minister is responsible for Health and **Social Care**. The Minister, who is responsible for the provision of mental health services, will be under a general duty in section 2(1) of the new Law to make provision for the **care** and treatment of persons suffering from mental disorder.

Amendment: None

PART 4:

GUARDIANSHIP

91 **Comment:** A question was raised regarding the use of Guardianship and if it satisfies the 'acid test' as set out by the Supreme Court regarding a deprivation of liberty. It was suggested that it may be entirely appropriate to use such powers but if they do amount to a Deprivation of Liberty there is a requirement under the ECHR that they carry safeguards. This is particularly so in the light of the proposed provision Article 31 Powers of re-taking into custody, and restraint.

Response:

It is important to recognise that imposing restraint on a person is not the same thing as depriving a person of their liberty. There is a difference in terms of degree and intensity between the two. Within the new Law the persons we expect to be subject to guardianship will often not be persons who would lack capacity to decide where they live, albeit that the application for guardianship will be founded on the basis that the person is mentally disordered and that in order to protect the person's welfare it is necessary for powers to be taken to decide

where the person will live and require that the person attend for certain medical treatment. They will have the right of appeal to the Mental Health Review Tribunal.

The power of restraint is intended to ensure that care professionals engaged in supporting a person subject to guardianship can have appropriate assurance that they can lawfully safeguard the person from harm. If the degree and intensity of support that a person requires means that they must regularly be detained and compulsorily treated then it may well be that guardianship is not the appropriate source of power to rely on.

Amendment: None

PART 5

OTHER FORMS OF LEGAL CUSTODY: PLACE OF SAFETY, ETC.

92 **Comment:** We received a number of comments regarding Article 34 which defines a place of safety. It was suggested that the use of police cells being the primary place of safety should be changed in favour of healthcare environments.

Response:

Article 34 has been revisited and the requested changes chime with the MHA 1983 codes of practice. Whilst there will be occasions on which a police station is the appropriate environment to provide a place of safety it should not be the primary place of safety. The Minister was clear in our discussions with him that police cells needed to be available as a place of safety under the new Law. However, this should only be the case where the person's behaviour would pose an unmanageably high risk to other patients, staff or users of healthcare settings (HO circular 007/2008)

Amendment: Article 34 (1) now reads:

“place of safety” means—

- (a) an approved establishment;
- (b) in a case where, for the purpose of preventing harm to the person in question or to any other person, a police station is the most secure or suitable place, a police station; and
- (c) any other place –
 - (i) which may be designated as such for the purpose by the Minister, or
 - (ii) the occupier of which consents to receive a person for a specified temporary period.

PART 6

TREATMENT REQUIRING CONSENT

93 **Comment:** We received comment that stated the issue of Second Opinion Appointed Doctors (SOAD) in the UK has been something of a ‘charade’ and gives an illusion of rights with a 96% agreement rate between the SOAD and the RMO. We were asked why have a SOAD scheme and how can it effectively deliver on its purpose.

Response:

We are of the opinion that the SOAD is an important safeguard for people subject to compulsory treatment. The process of peer review is highly likely to ensure compliance with good practice and can have a meaningful effect for patients by ensuring that there is independent assessment and review of the care plan. The SOAD will be a consultant psychiatrist, independent from Jersey and appointed by the Minister.

Amendment: None

PART 7

MENTAL HEALTH REVIEW TRIBUNAL

94 **Comment:** It was suggested that there may well be an argument for extending the role of the Mental Health Review Tribunal to consider other matters in relation to incapacity such as appeals against Deprivation of Liberty.

Response:

The Capacity Law was drafted simultaneously to the new Law. The Mental Health Review Tribunal will play an important role in reviewing a number of aspects of the Capacity Law. Within the Capacity Law the Tribunal may review an authorisation for the imposition of significant restrictions on liberty under Part 5 of that Law.

Amendments: None

95 **Comment:** It was noted that in the table in Part 2 of Schedule 1 there is no provision for an application on behalf of the patient by either representative (now nearest person) or independent mental health advocate. We consider the role of the Independent Mental Health Advocate to be crucial.

Response:

The patient's nearest person may make an application for a review to the MHRT. Where a patient is not able to exercise the right to apply to the Tribunal and the patient's nearest person has not done so, there will be a mechanism for those cases to be brought before the Tribunal so the legality of the person's detention can be determined. The appropriate mechanism for doing that is by a reference being made by the Attorney General or the Minister pursuant to Article 51 of the new Law. We recognise that the role of Independent Mental Health Advocate (IMHA) is an important one; however, we do not think it is appropriate for the IMHA to initiate an application on behalf of a patient in their own right under the new Law. The IMHA's role will be to support the patient and or the nearest person to understand their rights and to facilitate the participation of the person in the Tribunal process.

Amendment: None

96 **Comment:** A question was raised regarding the process by which application to the MHRT are made by those who lack capacity. It was stated that The European Court of Human Rights' decision in *MH v UK* highlighted shortcomings in English mental health law as a person who lacked capacity was unable to challenge the detention in a hospital under the MHA 1983 which violated her human rights. It was suggested that the Court ruled that special procedural safeguards are necessary to protect the interests of persons not capable of acting for themselves on account of their mental disabilities.

Response:

A person detained who lacks capacity to make an application to the MHRT can have an application made on their behalf by the 'nearest person' as if they had made the application themselves. The Code of Practice will describe best practice for referrals by the Minister or Attorney General to be made under Article 51, to the MHRT for those who have not made an application. We are of the opinion that this satisfies the concerns raised by the ECHR.

Amendment: None

97 **Comment:** With regard to references to the MHRT by either the Minister or Attorney General where a patient is liable to be detained under Part 3 or is subject to guardianship under Part 4, it states that '*the Minister or the Attorney General may, if he or she thinks fit, refer that patient's case*'. Concern was raised regarding the words "*if he or she thinks fit*" and the question was raised under what criteria would they use this power, or refuse to do

so? The comment concluded 'The human rights of a patient cannot depend on the discretion of an Agent of the State'.

Response:

An express statutory statement of the criteria by which the Minister makes his decision is not necessary and could introduce an inappropriate degree of rigidity into the system. The Attorney General and Minister will need to exercise their discretion in accordance with their obligation to act in accordance with Article 5 of the ECHR, arising from the Human Rights (Jersey) Law 2000. There is no basis for the statement that the human rights of a patient cannot depend on the discretion of a state agent. However, what was found in *MH v UK*, is that reliance cannot entirely be placed on the exercise of discretion by private individuals, such as a patient's nearest relatives, as the exercise of their discretion is not governed by public law.

Amendment: None

PART 8

CRIMINAL JUSTICE: INCAPACITY OF DEFENDANT

98 **Comment:** Concern was raised that in Part 8 of the new Law there was a 'mixing up' of mental incapacity issues with mental ill health issues. It was noted that Article 55 which reads;

"This Part applies where in any proceedings, whether on accusation or trial, it appears to the court that a person charged with any act (the "defendant") is, because of –

mental disorder; or

inability to communicate,

incapable of participating effectively in the proceedings, and any reference in this Part to incapacity shall be construed accordingly."

99 The comment refers back to the preamble to this legislation which states:

*"A LAW to make provision with respect to the care and treatment of persons suffering **mental disorder**, including offenders and other such persons subject to the criminal justice system; and for connected purposes"*

And asks if it is the intention that an inability to communicate becomes a form of mental disorder within the Jersey mental health law.

Response:

The new Law aims to replace the 1969 Law and the 1964 Law. It is accepted that there was a difficult decision to be made about where to place provisions governing the situation where a person is incapable of participating in criminal proceedings. The test for whether a person is incapable of participating in court proceedings is conceptually different from the standard test for assessing capacity under the Capacity Law, the latter deals with a person's capacity to make a particular decision at a particular time. Capability to participate in criminal proceedings involves more than the ability to make decisions, it also involves the ability to understand the nature of the proceedings and give evidence to advance the person's interests in the proceedings. It can only really be assessed globally and it might be that a person has capacity to make decisions on how to participate, but doesn't have the ability to do so.

On balance we considered that the new Law was the most appropriate place for these provisions because we also need to address the circumstances mentioned in Part 9, where a mentally disordered offender is capable of participating in the proceedings, but needs to be sentenced appropriately to enable them to obtain appropriate treatment.

We do not agree that it is right that a person should have both a mental disorder and an inability to communicate before they are treated as unable to participate in proceedings. That would clearly narrow the effect of the provision in an inappropriate way, it is to be remembered that a person's inability to communicate will only amount to a reason to treat them as being unable to participate where the inability cannot be remedied by the court taking special measures (see Article 56(3) and 57(4) and 58(1)).

Amendment: Change to the preamble of the law which now reads:

A LAW to make provision as to the care and treatment of persons suffering mental disorder; and as to the treatment, under the criminal justice system, of offenders and other persons who may suffer mental disorder; and for connected purposes

And Article 1 (4) more clearly defines the definition of capacity and reads:

In this Law, except in Part 8, a reference to a person's capacity or lack of capacity is, unless otherwise indicated, to be interpreted in accordance with the Capacity Law.

100 **Comment:** With regard to determining issue of incapacity there was a concern about the use of the word '*rational*' in Article 57 (1) (d), as it was suggested that it is a subjective term and incompatible with accepted assessments of capacity.

Response:

It is not accepted that the use of the word rational is incompatible with the test for assessing capacity. The ability to understand the nature of the decision and weigh the pros and cons of different courses of action is part of rational decision making. As noted above there is a qualitative difference between assessing capacity and determining when someone is incapable of participating in proceedings.

Amendment: None

Part 9

CRIMINAL JUSTICE:

POWERS OF COURT IN RELATION TO ACCUSED PERSONS SUFFERING MENTAL DISORDER

101 **Comment:** Concern was expressed with regard to the court having the power to remand to an approved establishment for a report in the absence of an appropriately resourced secure unit in Jersey. Furthermore a request was made for a clear definition for an "approved establishment".

Response:

The new Law enables the Minister to approve establishments, whether operated by HSSD or the private sector, for the care and treatment of mentally disordered people. That approach provides flexibility for the Minister to ensure that a varied and appropriate range of establishments are available, and to withdraw that approval as necessary. We note the issues raised regarding differing levels of risk within the ward environment. Article 5 enables the Minister to approve establishments subject to such terms and conditions as the Minister thinks fit. Those terms and conditions may cover the arrangements required in order to receive mentally disordered offenders and would address, in practice, the sensitivities that have been highlighted. Attempting to provide a more rigid definition of 'approved establishment' in the new Law is not necessary and would defeat the flexibility which is intended to apply to the Minister's power here. Furthermore, the court has to be satisfied on the written or oral evidence

of the approved practitioner or someone representing the managers of the establishment that arrangements have been made for the admission of the defendant. Such arrangements will include an appropriate risk assessment.

Amendment: None

102 **Comment:** The use of Interim Treatment Orders was questioned from a human rights point of view and it was suggested this may amount to 'double sentencing'. The statement was made that sending someone to hospital under a 'sort of' treatment order and giving the doctors up to six months before reporting back to the court was unnecessary and excessive. It was further suggested that the Court could remand under Article 63 in the pre-sentence phase.

Response:

Article 64 allows the Court to remand a defendant for assessment of the nature and degree of any mental disorder and to advise the court on disposal either through a treatment order or by other means. The equivalent interim hospital order in the MHA 1983 (section 38) allows for such an order to be in place for no longer than 12 months.

Amendment:

None

103 **Comment:** It has been suggested that Jersey is proposing an interesting approach towards restriction orders as in effect the court will impose them, control detention (leave of absence) and decide on discharge. The question is asked if the court will have sufficient flexibility to deal with restriction orders. In England there is a mental health unit within the Ministry of Justice who advise the Secretary of State on issues regarding restriction orders. Supplementary questions included:

- Will the patient be legally represented?
- How will this be funded?

Response:

The number of people in Jersey subject to restriction orders is likely to be extremely low and that small number who meets the threshold for such orders being imposed will almost invariably be detained off-island and would be dealt with under the equivalent English legislation. The

burden on the court / AG will be very light. Discussions will need to take place with the Law society, but we would expect a person on Jersey subject to a restriction order will be able to obtain legal aid as can a person detained under the new Law generally.

Amendment: None

104 Comment: A question regarding Article 69 Transfer Orders was raised and asked what rights a court transferred prisoner has to the MHRT. It was suggested that not being able to apply to the MHRT would be contrary to the ECHR.

Response:

We acknowledge that an amendment to Article 69 is needed so as to provide a right for a prisoner transferred to hospital to challenge their continued detention in an approved establishment. A successful application would result in the transfer order being cancelled and the prisoner being returned to prison. However, we feel an application for a transfer order to be cancelled should be made to the Court rather than the MHRT.

Amendment: Article 69 (8) (a) and (b) now states:

(8) A prisoner whose sentence of imprisonment has not expired may be discharged from the approved establishment to which he or she has been transferred under this Article –

(a) on an application made to the court by –

- (i) the prisoner, or
- (ii) the Attorney General;

(b) on the grounds that, in the opinion of the responsible medical officer, it is no longer necessary for the prisoner to be detained in such an establishment by reason of mental disorder.

105 Comment: It was suggested that the MHRT should be used rather than the Court for patients liable to Article 68 Restriction Orders and Article 69 Transfer Orders due to the costs and length of time associated with the court process.

Response:

The numbers are likely to be small. We believe the Court will be efficient in these matters and those people who are either sentenced or restricted by the court should continue to be dealt with through the court.

Amendment: None

PART 10

SAFEGUARDING: OFFENCES AGAINST THOSE IN RECEIPT OF CARE ETC.

106 **Comment:** It was suggested that within Article 78 *Information to be given to detained patients*, the managers of approved establishments should ensure all reasonable steps are taken to help the patient understand “what rights of access to independent advocacy” they have.

Response:

We agree with this comment.

Amendment: Article 78 (1) (a) and (b) to read:

(1) Where a patient is detained or taken into guardianship under this Law, the managers of the approved establishment in which the patient is detained or, as the case may be, the Minister must, as soon as practicable after the detention or guardianship commences, take all such steps as are reasonable to ensure that the patient understands –

(a) under which of the provisions of the Law the patient is detained or taken into guardianship, and the effect of those provisions;

(b) what rights of access to independent advocacy, representation and review are available to the patient under this Law;

107 **Comment:** It was suggested that Article 79 (1) ‘independent mental health advocates: regulations’ the word **must** should replace the word **may**. The law is currently drafted:

*“79(1) The States **may** make Regulations for the purpose of requiring the Minister to make arrangements for the provision of the services of independent mental health advocates (“MHAs”) to and on behalf of qualifying patients.”*

Response:

We believe this should be a discretion. It is for the democratically elected States Assembly to decide whether and how to exercise this discretion rather than compelling them to do so.

Amendment: None

108 **Comment:** It was suggested that the independent mental health advocate service **must** be independent to have any credibility and that the words “as far as is practicable” in Article 79 (2) (a) should be deleted.

Response:

Article 79(2) has been reworded and restructured so that the duty on the Minister to make arrangements for the appointment of IMHAs and their role is clearly spelt out in the new Law. The amended Article 79(2) does not include the wording “as far as is practicable”, however, the duty on the Minister is to make “reasonable arrangements”. While the Minister should seek to ensure the independence of the IMHA service, the “reasonable” standard has been included to acknowledge that, based on the nature and size of a jurisdiction like Jersey, it may not be possible at all times to appoint an IMHA who is completely independent. If complete independence is sought, which would be the case if the obligation on the Minister was cast in stricter wording, the provision of any form of an IMHA service could be prevented which would be to the detriment of patients.

Amendment: None

109 **Comment:** Further comment was made regarding Article 79 (3)

(c), method of appointment,

(d) terms and conditions and

(e) steps to be taken to ensure the patient is aware of the availability of the MHA

It was suggested that it should be the responsibility of the organisation which is appointed/commissioned to provide the service and that it would not be appropriate for the State to start micro-managing the service as this would undermine the very independence of the IMHA which is so essential.

Response:

We do not believe this is an example of micro-management. On the contrary, we feel it is important that the States and the Minister may be minded to consider such issues when appointing an independent body to support vulnerable people.

Amendment: None

110 **Comment:** In Article 79 (5) (c) the suggestion was made that the capacitated patient should have the explicit right to object to the disclosure and inspection of records to the IMHA.

Response:

Article 79 (5) (c) provides that Regulations may make provision as to circumstances in which a patient may object to the disclosure of records.

Amendment: None

111 **Comment:** A concern was raised that in Article 79 (6) the list of qualified patients excludes informal in-patient. It is suggested there is a clear role for the IMHA in ensuring that informal patients understand their rights and have the capacity to agree to be an informal in-patient.

Response: Patients who are voluntary as defined in Article 14 will have the right to seek out advice and support with regard to their care and treatment. However, their rights are not impinged in the same way that a detained patient or someone subject to a guardianship order is. Therefore, it is appropriate that the Minister makes provision for IMHA for people detained, liable to be detained or subject to guardianship. Furthermore, a patient receiving treatment as an outpatient (who is not liable to detention) should not be described as a qualifying patient under the law.

Amendment:

Amend Article 79 (6) by removing (c) a patient receiving treatment as an out-patient (under a care plan).

112 **Comment:** The issue of Article 83 'Restrictions on postal correspondence' was questioned and compared to the MHA 1983. It was highlighted that whereas in Jersey it is proposed that people detained in an approved establishment can have their postal packets withheld on the opinion of the manager in the interests of health and safety or for the protection of others; in England, postal packages can only be withheld in the same circumstances, by managers of high security hospitals. The comment suggested that what Jersey is proposing is more restrictive and questioned to what extent this would apply to someone under guardianship or on leave.

Response:

The provisions in Article 83 of the new Law are intended to apply only to those detained in approved establishments. 'Approved establishments' will be approved by the Minister but will include, principally, hospitals and care homes. A person subject to guardianship or on leave will not be detained in an approved establishment so will not be subject to the provisions in Article 83. Prior to a period of leave being granted a risk assessment will have been completed and such concerns will be addressed.

There is no intention to withhold or otherwise control the correspondence of a person who simply lacks capacity.

The position is different with a person who is suffering from a mental disorder as that condition may manifest itself in such a manner that, for example, causes the person to send malicious mail. In such cases, it is proper for those managing an approved establishment to have the ability to control potentially physically or emotionally dangerous correspondence.

As for the provisions in the MHA 1983 we have concerns that managers in non-high secure psychiatric hospitals are not able to intervene with detained patients postal packages in the interest of health and safety or for the protection of others.

Amendments: None

113 **Comment:** It was suggested that the Independent Mental Health Advocate should be added to the list in Article 83 (3)

Response:

We agree with this comment.

Amendment: IMHA has been added to the list in Article 83 (3)

114 **Comment:** It was suggested that Article in 83 (5) (a), a 7 day period to give notice in writing to the patient and, where appropriate, the addressee is too long and should be changed to 72 hours.

Response:

We feel 7 days is appropriate as time will be required for the correspondence to reach the addressee if they are not located in Jersey.

Amendment: None

PART 12

TRANSFER OF PATIENTS BETWEEN JERSEY AND OTHER JURISDICTIONS

115 **Comment:** The question was asked, will patients being transferred from Jersey by the Minister have the right to appeal their detention and the right to have this appeal heard by the Tribunal.

Response:

Article 85(1) provides that a patient may not be removed from Jersey unless authorised (a) by order of the court; or (b) by the Minister, with the approval of the Tribunal. Article 85(2) goes on to provide that where the Minister authorises removal under Article 86 or 87, the Minister must immediately notify the Tribunal and the Tribunal shall review the authorisation within the period of 7 days beginning with the date of such notification. As such, the MHRT or the Court will be involved in the process of removal of patients from Jersey.

Amendment: None

PART 13

MISCELLANEOUS AND GENERAL PROVISIONS

116 **Comment:** It was suggested that the principles which are likely to appear in the Code of Practice should be included in the primary legislation.

Response:

It is not considered appropriate or necessary to include a statement of principles underlying the provisions of the legislation in the new Law. Many of the decisions to be taken under the provisions in the new Law, for example as to detention and care or treatment, will be taken by experts in the field of mental health who will have regard to their professional standards. Including a provision setting out principles in the new Law itself would be too inflexible and might hinder advances in professional and ethical decision-making. This position here is different to that under the new Capacity Law, where a simple statement of interpretive principles is integral to the operation of the law and a wide variety of people may need to refer to the principles.

None the less, Article 90 of the new Law requires that principles with respect to the application of the new Law are set out in a Code of Practice

Amendment: None

117 **Comment:** With regard to Article 90 code of practice it was suggested that rather than stating the Minister **may** issue codes of practice it should be The Minister **must** issue codes of practice.

Response:

We agree with this comment.

Amendment: Change 'may' to '**must**' on the first line of Article 90.

SCHEDULE 1

PART 1:

CONSTITUTION AND PROCEEDINGS OF MENTAL HEALTH REVIEW TRIBUNAL

PART 2

APPLICATIONS TO THE TRIBUNAL

118 **Comment:** Concern was raised that the Table in Part 2 of the Schedule within the 'Period' column does not recognise that many patients are initially admitted to the establishment on an informal basis but are then, at some later point in time, detained under an Observation or Treatment order. So the table presently reads that where

*"Detention under an assessment authorisation" an applicant can appeal "14 days beginning with the day on which the applicant was **admitted** to the establishment".*

It was noted that a patient may, for example, have been an informal in-patient for 12 days at which point they are detained which would significantly reduce the period to appeal.

Response:

This mirrors the question raised regarding Article 20 above, the response is:

It is agreed that clarity was required.

Amendment:

Article 20 provides for the effect of an application for the admission of a person to an approved establishment for either assessment or treatment. Appeals to the Mental Health Review

Tribunal are described in Schedule 1, Part 2 within the table. For patients detained for assessment it states they are able to make an application to the tribunal within the first '14 days beginning with the day on which notice is given under Article 20(2) that the patient is **admitted to an approved establishment**'. For patients detained for treatment it states they are able to make an application to the tribunal '6 months beginning with the day on which notice is given under Article 20(2) that the patient is admitted to an approved establishment'.

Further Comments

119 Comment: Detail was provided regarding the death of a patient in a mental health hospital or nursing home as described in the current 1969 Law which is referenced within the Inquests and Post-mortem Examinations (Jersey) Law 1995. This requires deaths in such establishments to be reportable to the Viscount and this provision needs to continue within the new law. Reference was also made to the Nursing and Residential Homes (Jersey) Law 1994 and the need for consequential amendments.

Response:

This will be addressed through consequential amendments.

120 Comment: The issue of curatorship was raised and the understanding of the current provisions will be repealed from the new law with the new provisions being provided for in the Capacity Law. The question was asked if the new laws would be implemented together and what transitional arrangements will be made.

Response:

It is our aim that both the new Law and the Capacity Law will be implemented together. However, it is recognised that we will require the powers of curatorship described in the 1969 Law until the new Capacity Law comes into force if there is a delay.

Amendment: Article 97 (2) Repeals and saving

(2) Article 43 of the Mental Health (Jersey) Law 1969 (and, so far as necessary for the purposes of that Article, Articles 1, 3, 4 and Part 2 of, and Schedule 2 to that Law) shall continue to have effect until the commencement, if occurring after the commencement of this Law, of Part 4 of the Capacity Law.

The project team would like to thank all those people who have been involved in the process of developing this new law and for taking time to attend presentations read reports and responding in writing.