STATES OF JERSEY

DRAFT MENTAL HEALTH, CAPACITY AND SELF-DETERMINATION (JERSEY) AMENDMENT LAW 202-

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Lodged au Greffe on 11th February 2026
by the Minister for Health and Social Services
Earliest date for debate: 14th July 2026

STATES GREFFE

Jersey

DRAFT MENTAL HEALTH, CAPACITY AND SELF-DETERMINATION (JERSEY) AMENDMENT LAW 202-

European Convention on Human Rights

In accordance with the provisions of Article 16 of the Human Rights (Jersey) Law 2000, the Minister for Health and Social Services has made the following statement –

In the view of the Minister for Health and Social Services, the provisions of the Draft Mental Health, Capacity and Self-Determination (Jersey) Amendment Law 202- are compatible with the Convention Rights.

Signed: **Deputy T.J.A. Binet of St. Saviour**

Minister for Health and Social Services

Dated: 6th February 2026

REPORT

Introduction

The draft Mental Health, Capacity and Self-Determination (Jersey) Amendment Law 202- (the "draft Law") will, if approved, make a number of amendments to both the Mental Health (Jersey) Law 2016 ("the Mental Health Law") and the Capacity and Self-Determination (Jersey) Law 2016 ("the Capacity Law") following a review of both laws. The amendments made by the draft Law form a first tranche of amendments to both Laws, a further set of amendments are currently being developed in conjunction with stakeholders.

Background

Mental Health (Jersey) Law 2016

It is essential that the provision of mental health services continues to be underpinned with a modern and clear legal framework, which safeguards the rights, dignity and wellbeing of people experiencing mental health problems. This is also necessary to provide assurance to the public that those persons experiencing mental health problems and the public will be protected from harm. Prior to the introduction of the Mental Health Law the treatment of people affected by mental disorders was underpinned by the Mental Health (Jersey) Law 1969 (the "1969 Law"). There were a number of difficulties with the 1969 Law, and the main purpose of the Mental Health Law was to replace it with a piece of modern mental health legislation that was fit for purpose in the 21st Century.

Although the 1969 Law had, from time to time, been updated in some minor respects, it had not been updated comprehensively to reflect the many advances that have been made in the care and treatment of people experiencing mental illness, or to afford the safeguards for their dignity and liberty that are available elsewhere. Furthermore, while Jersey's mental health legislation must be appropriate for our own circumstances, it is also important that our legislation is sufficiently aligned with equivalent legislation in the UK and Guernsey. A person's circumstances, or the availability of specialist services elsewhere in the British Isles, will sometimes mean that a person needs to be transferred to another place in the British Isles to receive care. It is important that Jersey's legislation keeps pace to ensure that people can access the care they need, when they need it and with appropriate safeguards.

Capacity and Self-Determination (Jersey) Law 2016

Capacity issues could potentially affect anyone. A person's capacity to make some decisions may be impaired for a variety of reasons, such as having significant learning difficulties or mental health problems, suffering a stroke or head injuries, or the onset of dementia.

The Capacity Law works to safeguard the dignity and wellbeing of people who may not have the capacity to make decisions for themselves and enable them to make their own decisions wherever possible. It also ensures that where a person lacks the capacity to make a decision, there is someone appropriate able to support them, provides for a decision-making process and requires that any decision is made in that person's best interests.

While the Capacity Law drew inspiration from the Mental Capacity Act 2005 ("the 2005 Act"), it built on existing applicable policies and enshrined in statute relevant principles of Jersey customary law for the first time. Therefore, the provision of services for people who may lose capacity to make decisions for themselves has been underpinned, since 2018, with a modern and clear legal framework which safeguards the rights, dignity and wellbeing of people who may have lost the capacity to make a decision for themselves. It continues to provide assurance that the

person will be supported to make a decision for themselves wherever possible, and that any decisions which they cannot make, and which cannot wait, are made in their best interests.

Review of the Mental Health Law and the Capacity Law

The draft Law has been developed by two cross service working groups, made up of mental health professionals, legal advisors, court staff, Capacity and Liberty Assessors and policy officers. The two groups were set up in 2021 to review and identify issues with the two laws, as at the time they were seven years post enactment. The reasons for the amendments vary, some are required due to errors in the enacted Laws whilst others are required due to changing best practice. A number are also required due to the provisions in Law being based on English provisions. However, as a small island, our requirements and services are unique, and opportunities have emerged to update provisions to better suit services in Jersey and better protect patients and the public from potential harm.

Oversight of the two working groups was provided by the Mental Health Legislation Oversight Group. This existing cross-system group, which oversees all matters relating to the operational discharge of the provisions of the Mental Health Law and some provisions of the Capacity Law, was heavily consulted and has considered and shaped the proposals developed by the working groups prior to the Minister of Health and Social Services being briefed and providing approval for the legislative amendments. The membership of the Oversight Group is broader than the working groups and consists of:

- Director of Mental Health, Social Care and Community Services
- Heads of Service, and senior management of, Adult Mental Health Services,
- Adult Social Work Service,
- States of Jersey Police,
- Chief Executive Officer of MyVoice Jersey (the provider of independent mental health advocacy services),
- Learning Disability Service,
- Ambulance Service,
- Children and Adolescent Mental Health Services (CAMHS),
- Associate Chief Nurse.

Given the breadth of the required amendments, it was decided to bring forward the amendments in tranches, this draft Law forms the first tranche of the proposed amendments. The second tranche of amendments is currently being developed and considered by the various groups. The underlying policy work for the second tranche of amendments has also been required to consider the impact of amendments made by UK Government in the Mental Health Act 2025 that received royal assent just before Christmas last year.

Should the draft Law be approved by the Assembly several actions will be required before the draft Law is able to come into force. These include:

- Amendments to secondary legislation that prescribes certain matters as required by the primary legislation,

- Amendments that are required to both the Mental Health (Jersey) Law 2016 Code of Practice and the Capacity and Self-Determination (Jersey) Law 2016 Code of Practice, and
- Roll out of necessary training to staff required as a result of amendments made by the draft Law.

Key changes

Mental Health (Jersey) Law 2016

- Amendment of the term Authorised Officer to Approved Mental Health Professional
- Amendment to the provision that determines who a person's nearest relative is
- Amendment to which registered medical practitioners can authorise an Emergency Admission
- Change of status title from Approved Practitioner or Responsible Medical Officer to Approved Clinician and Responsible Clinician
- Correction of an error in the criteria for renewal of a Treatment Authorisation, as currently there is no explicit requirement that a patient continues to be suffering from mental disorder that warrants treatment
- Expansion of who may certify that a patient has given capacitous consent to treatment
- Correction of provisions regarding who must be consulted about treatment by a Second Opinion Approved Doctor (SOAD) before the SOAD issues a certificate approving treatment
- Improvements to the provision that enable restrictions to be placed on a detained patient's access to electronic media and electronic communications
- Improvements to the provision that permits postal correspondence to be withheld in appropriate circumstances
- Clarification of circumstances surrounding Applications to the Mental Health Review Tribunal ("the Tribunal")

Capacity and Self Determination (Jersey) Law 2016

- Correction of an error in the definition of what is considered to be restraint
- Consequent on the change in the definition of restraint, a provision treating existing restraining measures to be authorised under current SRoL standard authorisations
- Clarification of the process for the resignation of a delegate
- Correction of the use of the term deprivation of liberty
- Amendment to the provision that sets out the manner in which capacity assessments must be undertaken

Mental Health (Jersey) Law 2016

Amendment of the term Authorised Officer to Approved Mental Health Professional

Article 1 of the Mental Health Law currently defines an Authorised Officer as a person authorised by the Minister under Article 6 of that Law. An Authorised Officer is a health professional with specific training in the application of the Mental Health Law. They are responsible for making applications for admission to approved establishments (a hospital).

Article 6 sets out that:

> *(1) The Minister may authorize as officers for the purposes of this Law (including, where appropriate, for the purpose of carrying out functions conferred on the Minister under this Law) such persons –*
>
> *(a) as are registered pursuant to the Health Care (Registration) (Jersey) Law 1995; and*
>
> *(b) have such training and experience in the field of mental health and in the application of mental health legislation and practice as may be prescribed,*
>
> *upon such terms and conditions as the Minister may think fit.*
>
> *(2) An authorized officer must perform his or her functions under this Law –*
>
> *(a) with fairness and impartiality; and*
>
> *(b) in the best interests of any patient with whose care or treatment he or she is involved.*
>
> *(3) The Minister may revoke an authorization under this Article and may vary any terms and conditions upon which such an authorization is granted.*

However, the term Authorised Officer is used in a number of other laws for other purposes in Jersey and this results in confusion when other laws that contain Authorised Officers interact with the Mental Health Law and Mental Health Services. It is also felt by professionals that it would be easier to build a professional identity and culture around a specific unique title that isn't shared and that is protected, and that using a title which is recognisable to UK-qualified professionals would improve recruitment.

Additionally, including Mental Health in the term will make it simpler for service users, the public and other services to grasp what the role's core function is. England, Wales, and Scotland, make it clear that the Approved Mental Health Professional/Mental Health Officer is a Mental Health Professional, and the title is clearly linked to the qualification – i.e. it has status in that you can only use the title if you have passed your AMHP (Approved Mental Health Professional) or MHO (Mental Health Officer) training, this would be mirrored in Jersey: only someone approved by the Minister, having satisfied the prescribed requirements, would be able to refer to themselves, or be known, as an Approved Mental Health Professional.

To be authorised as an Authorised Officer currently, or as an Approved Mental Health Professional if this draft amendment law is approved, a set standard of training and experience must be achieved.

These training and experience standards are prescribed in Article 2 of the Mental Health (Miscellaneous Provisions and Prescribed Forms) (Jersey) Order 2018 ("the 2018 Order") and are as follows:

> *(1) A person authorized as an officer under Article 6(1) of the Law must be a person who –*
>
> *(a) fulfils one of the training requirements in paragraph (2); and*
>
> *(b) has the experience specified in paragraph (3).*
>
> *(2) The requirements mentioned in paragraph (1)(a) are that the person –*
>
> *(a) is trained as an Approved Mental Health Professional within the meaning given by the Mental Health Act 1983 of the United Kingdom, and has completed the Mental Health (Jersey) Law 2016 Introductory Training Programme;*

(b) is trained as a Mental Health Officer within the meaning given by the Mental Health (Scotland) Act 2015 of the Scottish Parliament, and has completed the Mental Health (Jersey) Law 2016 Mental Health (Jersey) Law 2016 Introductory Training Programme; or

(c) has completed the Mental Health (Jersey) Law 2016 Mental Health (Jersey) Law 2016 Authorized Officer Training Programme.

(3) The experience mentioned in paragraph (1)(b) is not less than 2 years' experience in such aspects of mental health legislation and practice as the Minister may consider appropriate.

It is not proposed to amend these training and experience requirements as part of the amendment of the use of the term Authorised Officer to Approved Mental Health Professional, but the reference to the 'Mental Health (Jersey) Law 2016 Authorised Officer Training Programme' will be amended to reflect the new title.

Amendment to the provision that determines who a person's nearest relative is

A person's nearest relative has important functions under the Mental Health Law. In particular, a nearest relative must normally be consulted before a decision is made to detain someone and admit them to an approved establishment for assessment or treatment. A nearest relative also has a right to apply to the Mental Health Review Tribunal for the patient to be discharged from detention.

Article 8 of the Mental Health Law determines who can be the nearest relative of a patient and the hierarchy for the acquisition of nearest relative status. A nearest relative is the patient's nearest person unless a nomination is made for another person to be that patient's nearest person under Article 10, or a nearest person is appointed by the Court under Article 11.

Article 8 consists of a number of tests in the order of which they are applied. The first test is located in Article 8(2) which currently sets out that: "*Where a patient (when they are not admitted for treatment) ordinarily resides with, or is cared for by a relative, that relative is the patient's nearest relative*".

The use of just the word 'treatment' in isolation in Article 8(2) is problematic. Its use restricts the application of the test for determining the nearest relative of a patient to those patients who are admitted to an approved establishment for treatment only. The drafting of the provision does not permit it to cover the situation of any other patient, for instance, the admission and detention of a patient in an approved establishment for assessment for a mental health condition. This restriction in the application of Article 8(2) means that the existing provision does not assist in the determination of who is the nearest relative of a patient admitted to an approved establishment other than where that patient is admitted for treatment purposes.

The draft amendment Law amends the provision to read "(when they are not admitted to an approved establishment)". This amendment will correct the initial test so that it can consider a patient's care arrangements when they are not admitted to approved establishments (in other words, who is it that ordinarily cared for that person before they became a patient), rather than simply considering the ordinary care arrangements of a patient in a case where that patient was one who was admitted to an approved establishment for treatment only. This reflects proper enactment of the original policy intention.

Amendment to which registered medical practitioners can authorise an Emergency Admission

The emergency admission power in Article 15 currently enables an Approved Practitioner, who after examining a voluntary patient considers that the patient is likely to be suffering from mental disorder and that allowing the patient to leave hospital would endanger either the patient's safety or the safety of others, to authorise emergency detention for up to 72 hours.

Currently, an Approved Practitioner is required by the 2018 Order to be a doctor who has substantial training in psychiatry and has been approved by the Minister for the purposes of the Mental Health Law. Generally Approved Practitioners are Consultant Psychiatrists, or senior staff-grade psychiatrists (but most staff-grade psychiatrists are not approved).

Emergency Admission under Article 15 involves the immediate detention of a person, who is already in hospital voluntarily, pending a full Mental Health Law assessment by two doctors (one of whom must be an Approved Practitioner) and an Authorised Officer. The use of such a power may be necessary, for example, where a patient suffering an acute episode of mental distress and is saying that they wish to leave hospital to end their life, or who is suffering auditory command hallucinations instructing them to hurt others which they may act upon if they are able to leave.

In 2025, the power was used 27 times at Clinique Pinel (13 times out-of-hours) and on 4 occasions at the General Hospital, with the average length of emergency admission being 20¼ hours. In 22 of those cases the patient was substantively detained as a result of the full Mental Health Law assessment which followed.

At present only Approved Practitioners can use the Article 15 power. This limitation in who may exercise the power has given rise to difficulties in practice and causes an increase in risk to vulnerable patients. Currently, where an Approved Practitioner is not available it may then not be possible to prevent a patient from leaving hospital and thus to prevent them from coming to serious harm or from harming others.

In relation to the inpatient mental health wards at St Saviour's Hospital there is usually no Approved Practitioner present on-site during out-of-hours periods; there is not <u>always</u> an Approved Practitioner present at other times, they may be engaged, for example, in reviewing other patients. Staff grade psychiatrists may well be present on the ward at these times but, generally, staff grade doctors are not Approved Practitioners and so cannot currently use the power.

At the General Hospital, there are potentially no Approved Practitioners on site for substantial periods of the day as they may be working at Clinique Pinel or in community locations, as well as there being none present during the out-of-hours period. While there is a psychiatric consultant on-call during the out-of-hours period there will inevitably be a period of time before they arrive at General Hospital, during which time the patient might leave the hospital.

This amendment, in addition to reflecting the change from Approved Practitioner to Approved Clinician, which is outlined further below, aims to address the problems described above by extending the availability of the Article 15 emergency admission power to any doctor with three or more years of post-foundation training experience, i.e.: staff grade doctors and above, of any specialty. The amendment does not go as far as legislation in Guernsey and the United Kingdom that extends the power of emergency admission to any medical practitioner of any level.

The amendment will enable staff grade psychiatrists at St Saviour's Hospital to authorise an emergency admission pending a full Mental Health Law assessment when a consultant is not available, with the full assessment then following during the day rather than (in some cases) having to take place at night.

At the General Hospital, the amendment will enable staff grade or more senior doctors, who have been appropriately trained, in the Emergency Department and on the wards to take immediate action to prevent, from leaving, a patient likely to have a mental disorder who would present a

significant risk to themselves or others, thereby avoiding the risk that the patient may leave before the on-call Approved Clinician arrives.

In either case, the next step after a patient is detained would be for the patient to have a full Mental Health Law assessment which will be an assessment by an Approved Clinician, unless an Approved Clinician decides to release the patient from detention earlier. Retaining the power to release a patient from detention to Approved Clinicians only, and not also staff grade doctors, will ensure that the risks to the patient's safety or the safety of others will always be fully considered by a *senior* mental health professional.

As part of the implementation plan for this amendment, training that covers assessing and carrying out emergency admissions will be provided to staff grade doctors prior to the Amendment Law coming into effect. This is to ensure that they are competent and confident in using the authorisation should the need arise. The intention for this change is for it to provide a backstop that improves patient safety. However, in the first instance an Approved Clinician will always be sought to conduct the Emergency Admission.

Change of status from Approved Practitioner and Responsible Medical Officer to Approved Clinician and Responsible Clinician

The introduction of Approved Clinicians (ACs) status into the Mental Health Law will enable formal roles under the Law in relation to detained patients to be carried out by a wider range of mental health professionals than at present. Currently, only a registered medical practitioner (a doctor) can be an Approved Practitioner and, consequently, a detained patient's Responsible Medical Officer. As mentioned above, the 2018 Order prescribes which doctors can be approved: Approved Practitioners are usually consultant psychiatrists or senior middle-grade psychiatrists.

The effect of the amendment would be that approval as an AC would not just be restricted to doctors. Approval could be granted to suitably qualified and experienced practitioners from other professions such as nursing, psychology, occupational therapy and social work. In suitable cases an AC could then become a patient's Responsible Clinician (RC).

Under the current Law, Approved Practitioners have roles including:

- making medical recommendations for detention;
- being a detained patient's Responsible Medical Officer, and therefore deciding whether to grant leave, setting the patient's treatment plan, overseeing and managing the patient's care and treatment, and deciding whether to discharge the patient from detention.

While the role of making medical recommendations for detention will continue to be reserved to those ACs who are also registered medical practitioners, ACs who are members of other professions would be able to become a patient's Responsible Clinician (RC), exercising some of the functions (as mentioned in the second bullet point above) which a Responsible Medical Officer currently has. It will be important to establish clear protocols for shared care when an RC is not a medical practitioner.

The proposed amendment will reflect arrangements which have been in place in England & Wales since 2008, will enable the implementation of a modern workforce configuration which, in turn, will enable Jersey's mental health services to recognise and make full use of skills and experience acquired by clinicians in England & Wales or other parts of the UK.

At present the fact that a senior nurse, psychologist, occupational therapist or social worker – who may have trained, obtained and exercised AC status in England & Wales – cannot perform a similarly senior and responsible role in Jersey means that individuals with that level of experience are not prepared to move to and work in Jersey. There have been multiple cases of potential

candidates for roles in Jersey pulling out when they have realised that they would not be able to utilise their AC status for which they have been trained.

Implementing AC and RC status will therefore increase the pool of potential candidates for senior clinical roles within the Jersey's Mental Health Service and accordingly lead to a widening of the skill-mix available. It will also enable a wider distribution of certain responsibilities across professionals which will assist in the management of caseloads within the service and provide the conditions to underpin a modern mental health service.

Approval as an AC, in Jersey, by the Minister will still be required, and the Minister will need to be satisfied that individuals possess sufficient experience and training in the field of Mental Health prior to approval.

The current required evidence of training and experience requirements to become an Approved Practitioner is set out in Article 3 of the 2018 Order. These existing criteria will need to be broadened to cover other Mental Health Professionals who will be able to hold Approved Clinician status as a result of the draft Law. It is recognised that it will not be practicable to provide, in Jersey, all the training and experience which an AC requires to be suitable for approval, and therefore the new requirement will be that, when an individual is a professional from the wider group of mental health professions, they have already been granted AC status in England & Wales.

Correction of an error in the criteria for renewal of a Treatment Authorisation, as currently there is no explicit requirement that a patient continues to be suffering from mental disorder that warrants treatment

Article 22(1) of the Mental Health Law provides for the authorisation of the admission of a patient to an approved establishment for treatment and sets out the various legal tests that have to be met for an application for admission to be authorised by the Minister. Those tests are:

> *(a) the patient appears to be suffering from mental disorder of a nature or degree which warrants the detention of the patient in an approved establishment for treatment; and*
>
> *(b it is necessary –*
>
> *(i) in the interests of the patient's health or safety, or*
>
> *(ii) for the protection of other persons,*
>
> *that the patient should be so detained.*

When first made, a treatment authorisation lasts for 6 months from the date of admission. Paragraphs (3) and (4) of Article 22 provide for the renewal of a treatment authorisation, initially for a further period of 6 months and then for periods of 12 months. Paragraph (4) requires that the Responsible Medical Officer (becoming the Responsible Clinician) must, within the 2 months prior to the end of a patient's liability to detention, examine the patient and make a report to the Minister recommending either of the following actions:

> *(a) the renewal of the treatment authorization, if it appears to the responsible medical officer that it is necessary –*
>
> *(i) in the interests of the patient's health or safety, or*
>
> *(ii) for the protection of other persons,*
>
> *that the patient should continue to be liable to be detained; or*
>
> *(b) that the treatment authorization should not be renewed.*

However, Article 22(4) does not currently contain an explicit requirement that the patient '(continues to) be suffering from mental disorder of a nature or degree which warrants detention for treatment'.

When comparing the tests that must be applied in relation to a renewal of any treatment authorisation, as set out above, with the legal test required for an initial admission the absence of the requirement that the patient (continues to) be suffering from a mental disorder of a nature or degree which warrants detention for treatment, is notable.

Additionally, Article 52(1) – which sets out the test which the Mental Health Review Tribunal must apply when considering any application from a patient concerning a detention – does include such a requirement.

The omission of the requirement is a simple oversight and one that is corrected by the amendment Law to fulfil the original policy intention of the Mental Health Law.

Expansion of who may certify that a patient has given capacitous consent to treatment

Article 41 of the Mental Health Law sets out that treatment of a kind which is defined in paragraph 2 of the Article (primarily the administration of medication for mental disorder for longer than 3 months) must not be given to a patient unless either:

> *"(a) the patient has consented to the treatment, and –*
>
> *(i) the patient's responsible medical officer, or*
>
> *(ii) any other approved practitioner,*
>
> *has certified in writing that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment and has consented to receive it;*
>
> *or*
>
> *(b) a SOAD has given a certificate in writing in accordance with paragraphs (4) and (5)."*

As a consequence of the introduction of Approved Clinicians, the list of the persons who may give a certificate confirming that the patient is capable of understanding the nature, purpose and likely effects of the treatment, and has given their consent to that treatment, needs to be updated.

The reference to the patient's Responsible Medical Officer will be changed to refer to "the Approved Clinician in charge of the treatment that is to be given to the patient". This person will often be the patient's Responsible Clinician, but in those cases where the Responsible Clinician is not a registered medical practitioner and does not have the ability to prescribe medication which the patient is taking then a different Approved Clinician (who can prescribe the medication in question) will be in charge of that part of the patient's treatment.

Alternatively, a different Approved Clinician, who is a registered medical practitioner, could sign the certificate confirming capacity to consent. This is, in effect, a continuation of the existing provision in paragraph (1)(a)(ii).

Finally, it is also proposed to expand the list in sub-paragraph (1)(a) to include a Second Opinion Approved Doctor (SOAD). A SOAD is an independent doctor who is approved by the Minister to provide a professional opinion about the suitability of a particular treatment. This is to allow for the occasional case where a patient who has previously declined to give consent to medication has changed their mind, and given their consent, during discussion with the SOAD as part of the procedure described more fully below. The current wording does not cater for this scenario and

requires that another Approved Clinician who is also a doctor must sign the certificate, and therefore it was felt appropriate to add it.

Correction of who must be consulted about treatment by a Second Opinion Approved Doctor (SOAD) before the SOAD issues a certificate approving treatment

As noted above, Article 41(1)(b) provides that, as an alternative to patient consent, a SOAD may provide a certificate. That certificate provided by the SOAD confirms that, having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition, the treatment should be given to that patient (paragraph (5)(b)).

Article 40, which applies to certain other forms of treatment including electro-convulsive therapy, contains a similar requirement, except that for those treatments a SOAD's certificate confirming that "it is appropriate for the treatment to be given to that patient" (paragraph (4)(b)) is required in addition to the patient's consent.

Paragraph 4 of Article 41 goes on to set out that a SOAD is not permitted to give a certificate referred to in Article 41(1)(b) unless the SOAD has consulted the patient's Responsible Medical Officer and one other person "who must be an authorized officer or mental health professional who, in either case, is or has been responsible for the treatment of the patient".

Paragraph 3 of Article 40 includes a requirement that the SOAD must consult the patient's Responsible Medical Officer and one other person "who must be an authorized officer or mental health professional who, in either case, is or has been professionally concerned with the treatment of the patient".

In relation to both provisions, the inclusion of a reference to an Authorised Officer is redundant. The role of Authorised Officer (becoming AMHP) does not include ongoing involvement in the care and treatment of a detained patient, therefore an Authorised Officer/AMHP is not in a position to provide any useful information to the SOAD. The reference to an authorised officer will therefore be removed from both provisions and will not be replaced with a reference to an AMHP.

Secondly, the references to the patient's Responsible Medical Officer need to be updated to reflect the introduction of Approved Clinicians. For a similar reason to that outlined in the section above, this cannot be a direct change of wording over to being the patient's Responsible Clinician. While it will often be the RC whom a SOAD will need to consult, where a patient's RC is not able to prescribe the medication concerned then a different Approved Clinician will be in charge of that part of the patient's treatment and the SOAD will need to consult them instead. Therefore, the SOAD will be required to consult "the approved clinician in charge of the treatment to be given to the patient".

Thirdly, the current wording of Article 41(4) in the relation to the second professional to be consulted – that that professional be someone "responsible for the treatment of the patient" – is problematic for two reasons: it will be the patient's Responsible Clinician or a different Approved Clinician who is charge of the patient's medication, rather than any other professional involved in their care, who is "responsible for the treatment of the patient". Secondly, the current wording of the Law limits the scope of who the SOAD can consult more than the original policy intention. Indeed, the original Law Drafting Instructions for the Mental Health Law set out that the SOAD shall consult "*two other persons who have been professionally concerned with the treatment of the patient, and of those persons one shall be the Responsible Medical Officer*".

The amendment substitutes the wording "responsible for the treatment of the patient" with "professionally concerned with the treatment of the patient", which:

- brings parity in the wording found in Article 40(3)(b) – (Treatment requiring both consent and a second opinion),
- reflects proper enactment of the original policy intention, and

- would also reflect the language in the equivalent provisions in the Mental Health Act 1983, (see section 58(4)) and the Mental Health (Bailiwick of Guernsey) Law 2010 (both of which informed the policy that underpins the Mental Health Law) which refers to the consenting practitioners as being those who have been "professionally concerned with the patient's medical treatment".

The combination of these changes means that, in those cases where the patient's Responsible Clinician is not a registered medical practitioner, the SOAD must consult:

- the alternative Approved Clinician who is in charge of the patient's medication, and
- a second mental health professional who is "professionally concerned" in the patient's treatment – who could be the patient's Responsible Clinician, or could be a nurse or social worker.

Improvements to the provision that can enable restrictions to be placed on a detained patient's access to electronic media and electronic communications

Article 82 of the Mental Health Law provides for the circumstances and process by which a detained patient's access to electronic media or communications or to a telephone can be restricted.

The draft amendment Law would amend the current provisions of Article 82 to achieve the following aims:

- Correct the wording of the provision so that it is clear the provision covers electronic media or electronic communications as originally intended,
- Clarify, through improvements to drafting, that any restriction must not be imposed unless the necessary grounds as set out in Article 82(1A)(a) or (b) have been met,
- Where a person wishes to request that a restriction be imposed on a patient, so that the patient may not contact that person, broaden who they can give notice to. Currently, someone is only able to request this from the Manager of the approved establishment; the amendment will enable notice to be given to either the managers or to the patient's Responsible Clinician.
- Remove, as unnecessary, a requirement for the managers to give formal notice of the restriction of a patient's ability to contact a specified person to the person who requested that the restriction be imposed.

Amendments made to Article 84 will clarify that the Mental Health Review Tribunal's ("the Tribunal") review of any restrictions imposed under Article 83 is concerned only with whether the grounds for imposing a restriction continue (at the date of the Tribunal's consideration) to exist. This is to remove uncertainty about whether the Tribunal's role could also extend to a retrospective review of whether the grounds existed when the restriction was first imposed, which was not the original policy intention. Changes to Article 84 also clarify the Tribunal's powers, in particular in relation to cases where the Tribunal determines that the grounds for a restriction continue to exist. In such cases, the Tribunal will nonetheless still be able to modify the restriction. For example, if the restriction which was imposed by the managers was to prevent the patient having any access to electronic devices, the Tribunal could direct that the patient be permitted some limited access under supervision.

Improvements to the provision that permit postal correspondence to be withheld in appropriate circumstances

Article 83 of the Mental Health Law provides for the circumstances and process by which a patient's access to postal correspondence can be restricted.

The draft amendment Law would amend Article 83 to achieve the following aims:

- Clarify, through improvements to drafting, that a restriction must not be imposed unless the grounds as set out in Article 83(1A)(a) or (b) are met.
- Clarify who must be provided, in writing, with notice of a restriction and therefore has a right to review under Article 84. This Article did not previously state that a person who has sent a postal item to a patient, which is then withheld from the patient, should be given notice and have a right of review. However, it did appear to require that a notice was given to a person who had requested that the patient be prevented from sending post to them. The amendment will make it clear that notice must be given to the sender of incoming post which is withheld from the patient, the addressee of outgoing post which is withheld from dispatch, and the patient in either case.

The draft amendment Law also amends Article 84 to clarify that the Mental Health Review Tribunal is not able to review the original decision made by the managers of the approved establishment, as this was not the envisaged role of the Tribunal in the original policy intention. The role of the Tribunal is to review whether the grounds for the restriction as set out in Article 83(1A) or 83(2) continue to exist, not whether the original decision was justified.

If the grounds no longer exist the Tribunal must order that the postal item be released to the patient, or dispatched (as appropriate). If the Tribunal determines that grounds continue to exist for withholding some, but not all, of the contents of a postal item then they may direct that some items are released while others continue to be withheld.

Clarification of circumstances surrounding Applications to the Mental Health Review Tribunal

Currently, Part 2 of the Schedule to the Law sets out matters relating to applications that may be made to the Tribunal. The current table has been improved and clarified to make it easier to interpret for members of the public.

The opportunity has been taken to add an entry setting out the specifics regarding matters relating to an application made to the Mental Health Review Tribunal following a decision by the Manager of an approved establishment to restrict access to electronic media, electronic communications or a telephone as per Article 82. Regrettably, details in relation to this type of application were missed out when the original table was drafted; inclusion will provide clarity for all involved where a restriction of this type is used.

The current table also does not properly set out who can make an application in respect of a decision by the Managers of an approved establishment to withhold a postal item as per Article 83. The entry has been amended, for clarity, to correctly itemise all persons able to make an application to the Tribunal in respect of a decision of this nature.

Capacity and Self Determination (Jersey) Law 2016

Correction of an error in the test that determines what is considered to be restraint

Article 9(2) of the Capacity Law sets out that:

For the purposes of paragraph (1), C restrains P if C –

> *(a) uses, or threatens to use, force to secure the doing of an act which P resists; and*
>
> *(b) restricts P's liberty of movement, whether or not P resists or objects to the restriction.*

The Article as currently enacted uses 'and' at the end of Article 9(2)(a) instead of 'or'. The original drafting instructions for the CSDL requested that the provision use the conjunctive term 'or'. As such, the current formulation of Article 9(2) is incorrect.

In practice, the effect of the current wording means that the definition of 'restraint' requires both limbs of Article 9(2) to be met for restraint to be established. As a result, measures which limit a person's liberty of movement, but do not involve the use or threat of force, do not constitute restraint. Such measures include, for example, the administration of sedative or psychotropic medication (sometimes called 'chemical restraint'), or the use of bedrails. These measures are, by their nature, forms of restraint, but do not currently fall within the definition. This was not the original policy intention and must be corrected – it was and remains the policy intention that restraint would be established if either of the restrictive effects in paragraphs (a) or (b) is met.

Requirement for provision treating existing restraining measures to be authorised under current SRoL standard authorisations

Significant restriction on liberty ("SRoL") is the framework of safeguards under the Capacity Law for people who need to be deprived of their liberty in a relevant place in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.

Part 5 of the Capacity Law provides a framework of provisions that provide for how an authorisation for a significant restriction on the liberty of a person ("P") residing in a relevant place may be granted by the Minister. As part of the procedure for applying to the Minister for an SRoL authorisation, a Capacity and Liberty Assessor appointed by the Minister must carry out, and is responsible for, an assessment of P, in conjunction with a registered medical practitioner. The assessment enables a report to be provided to the Minister confirming, among other things, whether it is necessary and in P's best interests to impose the requested SRoL. An assessment is made up of six elements that need to be undertaken as part of the authorisation process for SRoL.

The definition of an SRoL in Article 39(2) includes, in sub-paragraph (d), a reference to measures by which a person's "actions are controlled … by the application of physical force or of restraint as defined in Article 9(2)". As a consequence, a measure which is not within the definition of restraint in Article 9(2), and does not otherwise involve force, does not fall within the definition of an SRoL either. This has prevented measures that are in use, and which are necessary, in the best interests of P and in line with usual practice, from being lawfully authorised, as only measures which fall within the definition of an SRoL can be authorised by the Minister.

When the error in the drafting of Article 9 was discovered, it was decided, by the Mental Health Legislation Oversight Group to adopt a policy-led approach with regards to when the definition of restraint is met until such time that the amendment Law was ready to be lodged so that the Capacity Law could be corrected. Therefore, assessments undertaken in relation to applications for Significant Restriction of Liberty (SRoL) authorisations have identified measures which would be considered to be restraint were the word 'or' used in Article 9(2), and have commented upon whether those measures were considered to be necessary, proportionate and in the person's best interests. However, because such measures are not legally considered to be 'restraint' due to the error in Article 9(2), and therefore not one of the specified SRoLs in the list in Article 39(2), the Minister has been unable to include them in the measures which have been authorised.

When the amendment to correct Article 9 takes effect, such measures will then fall within the definition of an SRoL in Article 39(2) and Article 38 will require that they only be imposed if appropriate authorisation is in place. Therefore, without further transitional provisions, the amendment would cause all current SRoL cases where such measures have been identified to require immediate re-assessment so that the chemical or other non-physical restraint can be formally authorised, otherwise the relevant care manager would become in breach of Article 38. This would require a significant proportion of current SRoL Authorisations to be re-assessed and re-authorised. As such, a transitional provision has been developed to avoid this.

Paragraphs (9)(10)(11) & (12) of Article 48 as amended by the draft amendment Law (the "transitional provisions") will operate to extend any existing standard SRoL authorisation, which is in place on the date the draft Amendment Law commences, to include relevant measures that have been recommended in the Capacity and Liberty Assessor's report which led to that authorisation. The transitional provisions are constructed so that no further assessment is required and without any further notification of authorisation being issued by the Minister.

The measures that the draft amendment Law seeks to authorise by the transitional provisions are only those measures that were recommended in the assessors' report as being necessary, proportionate and in the person's best interests and which (as a consequence of the amendment) will now fall squarely within the description of an SRoL under Article 39(2)(d) as the original policy always intended. Additionally, the authorisation of these measures will take effect only from the point that Article 9(2) is amended by the draft amendment Law. The transitional provisions do not authorise anything that is not recommended in the assessor's report, nor anything that would fall outside of the description of an SRoL under Article 39(2)(d), nor does it retrospectively give authorisation for things done at any time before the amendment Law takes effect.

The transitional provisions contain a sunset clause that will expire those provisions 12 months after the amendment Law is registered. This is because the maximum length of time that any SRoL can be authorised for is 12 months.

Clarification of the process for the resignation of a delegate

A delegate is someone appointed by the Court with ongoing legal authority, as prescribed by the Court, to make decisions on behalf of a person who lacks capacity to make particular decisions.

Article 34(10) currently provides that the appointment of a delegate shall cease upon the death of the delegate or upon the death of the person concerned ("P"), "*or upon the delegate's resignation*". The Capacity Law does not prescribe any requirements or process for the resignation of delegates. There is a problematic trend among some delegates of resigning as a delegate without taking any steps to line-up a potential replacement delegate or undertake a comprehensive and up to date handover of matters for the benefit of those who may need to act as delegate in their place. These cases tend to involve low asset cases where continuing to act as delegate for P does not present itself as an attractive proposition for some professional delegates. In such cases it is often the Viscount, as delegate of last resort, who is then appointed to act as delegate. Taking on increasing numbers of these types of cases is a concern to the Viscount owing to limited resource in the Department and the difficulty in establishing the relevant information to properly undertake the appointment.

Under the Mental Health (Jersey) Law 1969, a curator who wished to cease to hold office would, through the intermediary of the Attorney General, deliver to the Court the curator's resignation in writing. The Court would then determine whether to accept the resignation and the Court would then appoint a new curator. It is considered that Court oversight of curator resignations amounted to an important step in the process by which curators resigned and new curators were appointed, ensuring that there was continuity in appointment and that there was a check on those cases which were directed to the Viscount as curator of last resort.

The Viscount, staff from the Judicial Greffe, legal advisers and policy officers have agreed new operational guidance by which resignations of delegates will now be managed. The guidance covers cases where a delegate wishes to resign and has identified a replacement delegate; where a delegate wishes to resign because it is considered the appointment of a delegate is no longer required; and where a delegate wishes to resign where no replacement delegate has been proposed. In each case the guidance sets out the relevant steps and documentation which is to be submitted in support of a delegate's resignation. By way of illustration, where a replacement delegate has been found, the procedure will require the resigning delegate to coordinate the submission to the Court of a completed 'appointment of delegate' application form (DPA01) and supporting documentation, and for those resigning delegates who have been unable to coordinate a replacement delegate, they must submit a letter to the Judicial Greffe setting out evidence of the steps they took to find a replacement delegate.

It is not proposed to prescribe in the Law the detailed requirements which resigning delegates must comply with – as those requirements should remain open to refinement or amendment as need dictates. The Capacity Law will, however, be amended to ensure it is clear that delegates cannot in law unilaterally and immediately resign from the court appointed role of delegate.

To address this, it is proposed to amend Article 34(10) to remove the words "or upon the delegates resignation" to remove the perceived right for delegates to resign from appointment with immediate effect upon the submission of some form of a resignation letter. It will then be for the guidance to set out that the Court must consider a resignation and decide an appropriate course of action. Capacity matters hold a regular weekly court diary slot and this means there is a regular opportunity at which an appointment or replacement application, that would follow an application of resignation being submitted, can be heard by the Court.

Correction of the use of the term deprivation

Article 41(1) of the Capacity Law provides that the "*Minister must not authorize the imposition of a significant deprivation of liberty…*", and then paragraph (1)(b) refers again to "*necessity for such deprivation of liberty*". The use of the term *deprivation* in the Capacity Law appears to be an error in drafting as the correct terminology used throughout Part 5 is 'significant *restriction* on liberty'. Article 56 of the draft amendment Law inserts the correct wording into Article 41.

Amendment to the provision that sets out the manner in which capacity assessments must be undertaken

As outlined above, Part 5 of the Capacity Law includes a procedure for a Capacity and Liberty Assessor to carry out an assessment of the person who is subject to restrictions ("P") so as to enable a report to be provided to the Minister confirming, among other things, whether it is necessary and in P's best interests to impose the requested SRoL.

Article 44(2) provides –

> *"The assessment must be carried out by means of one or more interviews –*
>
> *(a) with P; and*
>
> *(b) in any case where –*
>
> *(i) the assessor is not a registered medical practitioner, or*
>
> *(ii) there is no medical evidence of P's lack of capacity at the date of the assessment,*
>
> *with a registered medical practitioner, in accordance with paragraph (3), who has seen P immediately before the assessment."*

Since enactment this provision has proved problematic in practice for a number of reasons and is considered to contain aspects in need of refinement –

1. In practice the "assessor" who will conduct the assessment will always be a C*apacity and Liberty Assessor*, i.e. a HCJ social worker who is not a registered medical practitioner. As such, assessments under Article 44(2) would never be performed by a registered medical practitioner and, for this reason, paragraph (2)(b)(i) ("*the assessor is not a registered medical practitioner*") is considered to be redundant and should be removed for clarity.

2. The wording "*no medical evidence of P's lack of capacity*" is inaccurate because the test for lack of capacity under the Capacity Law is not solely a medical test. It is a multi-step test which requires an assessment of P's cognitive ability in addition to an assessment of the underlying medical condition which affects that cognitive ability (see the formulation of the test for a lack of capacity at Article 4(1)(b)). As such the reference in Article 44(2)(b)(ii) to "*medical evidence*" of lack of capacity is a misnomer – it suggests medical evidence is capable of establishing a lack of capacity, which it cannot do. Medical evidence is relevant only to establishing that P does or does not suffer from an "*impairment or a disturbance in the functioning of his or her mind or brain*". For this reason, it is proposed that paragraph (2)(b)(ii) should be amended, by the draft amendment Law, to better reflect the nature of the medical evidence to which assessors must refer in undertaking the Article 44 assessment.

3. Article 44(2)(b) currently sets out the circumstances in which an assessor must consider medical evidence from a registered medical practitioner as part of the assessment of P for whom an SRoL is being considered. Article 44(2)(b) provides that the assessor must consider medical evidence (which presently would require the assessor to interview a registered medical practitioner) if there is no recently documented medical evidence "at the date of the assessment". In such cases, a registered medical practitioner would be required to have "seen P immediately before the assessment" triggering the automatic need for an examination of P.

   These provisions have been identified as presenting issues in practice. In some cases the SRoL which is to be authorised might be one which lasts only for a very short period of time or is being considered for a person who has a medical condition which has been diagnosed some time ago and is a condition from which the person will not recover (e.g. dementia).

   From a practice perspective, the current phrase "at the date of assessment" has been interpreted as requiring, in all cases, a medical examination of P by a registered medical practitioner in conjunction with the interview of P carried out by the assessor under Article 44(2)(a). It has been identified that there is a need to clarify provisions in the Capacity Law that provide for historic medical evidence of established and irreversible conditions (e.g. dementia) to be relied on for the purposes of the assessment under Article 44(2), foregoing the need for P to be examined medically by a registered medical practitioner in addition to being interviewed by an assessor.

   There is a concern that the medical examination of persons affected by irreversible medical conditions which have already been clearly diagnosed and/or for whom a short term SRoL is being considered would constitute a disproportionate interference with P's rights or have an unnecessary detrimental impact on P's wellbeing and, additionally, results in inefficient use of resources. Moreover, in the case of conditions such as dementia, there would be little if any development in P's condition which could usefully

be examined and reported on by a registered medical practitioner, and the reduced involvement of registered medical practitioners in such cases (e.g. written communication from the registered medical practitioner) would be sufficient and an appropriate alternative for the purposes of the SRoL assessment.

For comparison, under the current Deprivation of Liberty ('DOLs') regime set out in the Mental Capacity Act 2005 (the "MCA 2005"), the supervisory body (the local authority body which approves deprivations of liberty under the that legislation) is able to avoid the need to carry out one of the number of assessments required in order to issue a deprivation of liberty authorisation if a number of conditions are complied with. Those conditions include that the existing assessment was carried out within the previous 12 months, and the supervisory body is satisfied that there is no reason why the existing assessment may no longer be accurate[1].

The DOLs regime in the 2005 Act has been amended by the Mental Capacity (Amendment) Act 2019 (the "2019 Act"). The 2019 Act makes a number of amendments to the DOLs regime which are intended to improve the existing system following numerous reviews and calls for reform of the system. The amendments include changes to the assessments to be carried out in connection with obtaining a standard authorisation. Among the changes, new Schedule AA1 paragraph 21(8) permits those making determinations on capacity and medical assessments to rely upon assessments carried out previously, including those prepared for another purpose, so long as it is reasonable to do so. Paragraph 21(9) sets out the factors that can be considered when considering whether it is reasonable to rely upon an existing assessment. The intention of the changes made by the 2019 Act is that an existing assessment can be relied on, provided it gives a reliable indication of the person's current situation.

Accordingly, it is considered that, for the purpose of the determination to be made under Article 44(6), an assessor should be able to rely on the evidence of a registered medical practitioner who has examined P within the period of 12 months before the date of the Article 44(2) assessment provided the assessor is satisfied that there is no reason why the medical evidence may no longer be accurate, and the assessor should be able to consult medical evidence in the form of either a consultation with the registered medical practitioner (e.g. by telephone) or by consulting P's medical records. If P's impairment of the functioning of the mind or brain has not yet been diagnosed medically or, in those cases in which it has been but P has not been examined within the period of 12 months of the date of the SRoL assessment, or where the assessor is not satisfied that the medical evidence remains accurate, a registered medical practitioner would still be required to examine P and the assessor would be required to consult the registered medical practitioner immediately before conducting the Article 44(2) assessment in the usual way.

4. An associated issue is that Article 44(2) requires the assessor to conduct "interviews" with registered medical practitioners. In England and Wales, comparable practice in the case of deprivation of liberty under the MCA 2005 is that those undertaking the assessment are able to rely upon medical records rather than having to 'interview' the medical assessor on each and every occasion. The draft Law, if approved, would enable assessors carrying out an assessment under Article 44(2) to have the option of consulting P's medical records, or alternatively by 'consulting' the registered medical practitioner which could include obtaining their opinion through correspondence.

   For comparative purposes, under the MCA 2005, the supervisory body is able to give a standard authorisation for a deprivation of liberty if it has written copies of the relevant assessments that are required to be undertaken as part of the UK scheme (which include a medical assessment)[2]. As such, in issuing measures equivalent to those which amount to SRoLs under the Jersey law, the MCA 2005 does not require in-person interviews with

medical practitioners and enables consultation with written records of assessments, the draft Law would enable these arrangements to take place in Jersey.

Section C: Effects

Part 1 Mental Health (Jersey) Law 2016 - amended

Article 2 amending Article 1 and inserting Article 1A

Article 2 amends Article 1 by inserting a number of new definitions. A key change is the term used for persons approved by the Minister under Article 6 of the Law which is being changed from Authorised Officer to Approved Mental Health Professional (AMHP).

Article 2 also inserts Article 1A which defines the term 'Responsible Clinician' and extends the term to apply to the clinician with overall responsibility for patients remanded or detained by order of the Courts under Articles 62, 63, 64, 65, 67 and 67 in Part 9. Article 1A also sets out who is able to exercise the functions of a responsible clinician if they are unable to perform them.

Article 1A(3) sets out that if a registered medical practitioner has been authorised to act as a responsible medical officer in relation to a patient subject to guardianship under the current Law, that authorisation will be treated as an authorisation of the responsible medical officer as a responsible clinician.

Additionally, the amended Article will now define a "postal item" rather than relying on a definition within UK legislation that could be subject to change.

Article 4 substituting a new Article 6

Article 4 substitutes a new Article 6 into the Mental Health Law. As mentioned above, this Article will create the role in statute of an AMHP, which will directly replace the Authorised Officer role that previously existed in the Mental Health Law.

Article 6 amending Article 8

Article 8 of the Mental Health Law determines who a patient's nearest relative is. Article 6 of the draft Law makes an amendment to Article 8. Article 8(2) currently sets out that where a patient ordinarily resides with a relative (as defined in Article 8(3)), or is cared for by a relative, when they are "not admitted for treatment" then that relative is the patient's nearest relative.

The Article is amended to refer to the position "when not admitted to an approved establishment", thereby also excluding periods when the patient is admitted for assessment.

An incorrect cross-reference in paragraph (5)(a) is also corrected.

Article 8 amending Article 10

Article 10 of the MHL sets out the specifics for the nomination of a nearest person. The expression "in writing substantially to the same effect" has been changed to "in writing by giving substantially the same information as is required to be given in the prescribed form" to make it clearer what information a patient needs to give if they are not using the statutory nomination form. The structure of the Article has also been revised to improve clarity, including by separating the provision regarding revocation of a nomination into a separate paragraph.

Article 9 amending Article 13

Article 13 sets out the rights of a patient's nearest person to receive information about the patient's care or treatment. Obligations to provide information to the nearest person, which currently rest

solely with the responsible medical officer alone, will now be shared between the patient's responsible clinician and the managers of the approved establishment. This will increase the range of professionals who, in law, are obliged to provide information to a patient's nearest person, improving the timely flow of information.

Article 11 substitutes a new Article 15

Article 15 makes provision for the authorisation of the emergency admission of a patient who is present at an approved establishment, appears to be suffering from mental disorder and no longer consents to remain, where allowing them to leave the approved establishment would endanger their own safety or that of others. Currently only Approved Practitioners can authorise an emergency admission. This would change to an Approved Clinician (which replaces approved practitioner) and also be extended to any registered medical practitioner who has a minimum of three years post foundation training experience. This level of registered medical practitioner is usually known as a staff grade doctor. A patient can be released prior to the expiry of the 72-hour period by an approved clinician.

Article 12 substitutes a new Article 16

The effect of Article 12 is to substitute a new Article 16 into the Mental Health Law. The new Article 16 provides for the status of Approved Clinician. Persons registered in respect of a registrable occupation under the Health Care (Registration) (Jersey) Law 1995 are added to the list of individuals whom the Minister may approve under Article 16, alongside registered medical practitioners. Paragraph (3) is a new transitional provision that ensures that practitioners approved under Article 16 before this Law comes into force as "approved practitioners" will automatically be taken to be "approved clinicians".

It is important to note that Article 3 of the Mental Health (Miscellaneous Provisions and Prescribed Forms) (Jersey) Order 2018 currently prescribes the required evidence of training and experience requirements for Approved Practitioners. This Order will be amended, prior to the draft Law coming into force, to prescribe the training and experience requirements that will need to be present for clinicians of registerable occupations in order for them to be granted approval by the Minister.

Article 14 amending Article 22

Article 14 amends the grounds, provided in Article 22, that must be present to renew a treatment authorisation, so that they mirror the grounds required for an initial treatment authorisation. Currently, the grounds to renew a treatment authorisation do not require that the patient "must appear to be suffering from mental disorder of a nature or degree that warrants the detention of the patient in an approved establishment". This renewal ground was missed out of the current Law and must be inserted.

Article 15 amending Article 39, and Article 18 amending Article 44

Article 39 permits treatments which are not covered by specific provisions in Articles 40 and 41 of the Law to be given without the patient's consent provided they are given by or under the direction of the patient's responsible medical officer. Article 44 provides for the authorisation of treatments which *are* covered by those specific provisions in cases of emergency.

Article 15 replaces the references in Article 39 to the responsible medical officer, to align with the change of status driven by the substituted Article 16 already referred to. It substitutes the term "approved clinician in charge of the patient's treatment" for consistency with the other articles in

Part 6 of the Law where this term will also be introduced for the reasons outlined below. Article 39 makes the same change to Article 44.

Article 16 amending Article 40

Article 40 sets out the procedure for authorising certain types of treatment. Article 16 amends Article 40(3) to update the reference to a "patient's responsible medical officer" to "approved clinician in charge of the treatment that is to be given to the patient". This is to align with the change of status driven by the substituted Article 16 made by this draft Law.

The reference to an authorised officer being consulted by a Second Opinion Approved Doctor (SOAD) is deleted as it is redundant, because authorised officers are not involved with a detained patient's care and treatment on an ongoing basis.

Article 17 amending Article 41

Article 41 sets out two procedures for authorising the administration of medication to treat mental disorder when more than 3 months have elapsed after it is first administered, and also for authorising any other treatments prescribed by the Minister (no such treatments have yet been prescribed). Article 17 makes several substantive amendments to Article 41.

References to the patient's responsible medical officer are changed to align with the change of status driven by the substituted Article 16 made by this draft Law. The term "approved clinician in charge of the treatment that is to be given to the patient" is used instead, to allow for cases where the patient's responsible clinician is not a registered medical practitioner and cannot prescribe medication, in which case a different approved clinician will oversee that part of the patient's treatment.

Article 41 provides a procedure for a patient to consent to treatment, in relation to which Article 17 adds a Second Opinion Approved Doctor (SOAD) to the list of practitioners who may certify that a patient has the mental capacity to give consent to treatment and has given that consent.

Article 41 also sets out an alternative procedure by which a SOAD can certify that, although the patient lacks the capacity to consent to the treatment, or has refused to consent, the treatment should nonetheless be given to the patient. Two amendments are made to that procedure by the draft Law. The reference to an authorised officer being consulted by a SOAD is deleted as it is redundant, for the same reason as the equivalent amendment made to Article 40. Additionally, the definition of the second mental health professional whom the SOAD must consult is changed to be "a mental health professional who is or has been professionally concerned with the treatment of the patient". This term avoids overlap with the role of the responsible clinician and aligns with the language used in Article 40(3)(b).

Article 19 amending Article 47

Article 47 concerns the panel from which members of the Mental Health Review Tribunal may be drawn.

As a consequence of the change in status made by the new Article 16 substituted by the amendment Law, the requirement that medical members must be approved practitioners needs to be updated. However, it is not intended to change the requirement that medical members must be registered medical practitioners. Therefore, the reference to an approved practitioner is replaced with "a registered medical practitioner who is an approved clinician".

Article 20 substituting Article 50

Article 20 restructures Article 50 for the purpose of clarity, with the provision setting out the rights of a patient or their nearest person to apply to the Mental Health Review Tribunal moved to a new Article 50A (see below). A reference to the Tribunal's existing function regarding the approval of authorisations for the transfer of a detained patient to a hospital off island is also added for clarity, and drafting is updated to reflect current drafting practice.

Article 21 inserts a new Article 50A

A new Article is inserted to more clearly introduce the rights of a patient or their nearest person (and others, in limited circumstances) to make applications to the Mental Health Review Tribunal.

Article 22 amending Article 51

The types of detained patient in respect of whom the Minister or Attorney General may make a referral to the Mental Health Review Tribunal is expanded to include patient's detained under an unrestricted treatment order made by a Court. At present this group of patients are treated in the same way as patients detained under Article 22 for almost all purposes (including making applications to the Tribunal themselves), except that the Minister and Attorney General cannot make referrals to the Tribunal.

Article 23 amending Article 60

The amendment Law introduces a new term for reports that are required to be provided to a Court by various Articles in Part 9 of the Law. A "mental condition report" is defined as a report on the defendant's mental condition.

Article 24 amending Article 61

The amendments to Article 61 centre on defining the report in which the provision centres upon more clearly. The amendment to the drafting and inclusion of the new term or "mental condition report" clarifies, beyond doubt, the purpose of the report.

Article 25 amending Article 62

Article 25 amends Article 62 to update the drafting style of Paragraph (1), it also inserts the term "mental condition report" for the purposes of clarity.

Paragraphs (2) & (3) are amended to replace the term Approved Practitioner with Approved Clinician as per Article 12 of the draft Law. It also inserts the term "mental condition" to correspond with changes made to this part to clarify the types of reports being required.

Paragraph (5) is amended simply to update the term medical practitioner to "registered medical practitioner" to clarify that all medical practitioners must be registered.

Articles 28, 29 & 30 amending Articles 65, 66 & 67 respectively

Similar to above, all three Articles contain a reference to "medical practitioners" when the required reference should be to "registered medical practitioners", the amendment Law corrects this reference.

Articles 32, 33, 34, 35, 36, 37, 41 to 42 and 45 amending Articles 73, 74, 75, 76, 77, 80, 91 & 92 respectively

These Articles update the structure of the existing offence provisions to accord with modern drafting style, they do not change any of the effects of the offence provisions that are amended.

Article 38 amending Article 82, Article 39 amending Article 83 and Article 46 substituting the current Part 2 of Schedule with a new version of Part 2

Article 82 of the Mental Health Law currently provides for the circumstances where access to electronic media, communications or to a telephone may be restricted. Article 82(3) refers to the right of review of a decision to restrict communication available under Article 84. Article 84 sets out the right of review.

Article 83 provides for the restriction of postal correspondence and refers to a similar right of review under Article 84. Part 2 of the Schedule to the Mental Health Law then deals with 'Applications to the Tribunal' and sets out the types of application and applicants in respect of the review of specified decisions in the table set out in the Schedule. The review of an Article 83 decision to restrict postal correspondence is included in the table, however there is no mention of the review of an Article 82 decision to restrict e-communication etc, despite this being available under Article 84.

The absence of reference to Article 82 in the table in the Schedule appears to have been an oversight in the drafting of the table.

Article 46 substitutes a new Part 2 into the Schedule

A new clarified table of applications that can be made to the Mental Health Review Tribunal is substituted into the Schedule to the Law by Article 46 for the reasons explained above.

Article 47 amending further references to approved practitioner

Article 47 makes all the other required consequential amendments to replace the term "approved practitioner" with "approved clinician".

Article 48 amending further references to authorized officer

Article 48 makes all other consequential amendments to replace the term "authorised officer" with "AMHP".

Article 49 amending further references to application rights provided by Article 50(1)

Article 49 makes amendments that are consequential to Article 20 & 21 of this Law to change references to "rights conferred on a patient by Article 50(1)" to "the right to make applications to the Tribunal under Article 50A".

Article 50 provides for Schedule 1 that makes required consequential amendments across various primary legislation.

Article 50 introduces Schedule 1 that contains amendments consequential to Part 1 of the draft Law. It also replaces outdated references to the 1969 Law in two enactments.

Part 2 - Capacity and Self-Determination (Jersey) Law 2016 amended

Article 52 amending Article 9

Article 52 substitutes the word "and" for the word "or" in Article 9(2)(a). The Article as currently enacted uses 'and' at the end of Article 9(2)(a) instead of 'or'. The original drafting instructions for the CSDL requested that the provision use the conjunctive term 'or'. As such, the current formulation of Article 9(2) is incorrect. In practice, the effect of the current wording means that the definition of 'restraint' requires both limbs of Article 9(2) to be met for restraint to be established.

Article 53 amending Article 34

Article 53 amends Article 34(10) to remove the words "or upon the delegate's resignation" removing the perceived right for delegates to resign from appointment with immediate effect upon the submission of some form of a resignation letter. It will then be for the guidance to set out that the Court must consider a resignation and decide an appropriate course of action in the usual way common for other Court Orders.

Article 54 amending Article 37

Article 37 substitutes an altered definition of "relevant place" into Article 37(3) (interpretation and application of Part 5) of the CSDL, the definition if clarified and amended to make clear that the Minister may designate a relevant place a place that provides either health or social care or both health and social care, thus fulfilling the original policy intent.

Article 55 amending Article 38

Article 55 amends Article 38 to restate and clarify that a manager of a relevant place must not impose a significant restriction of liberty on P unless 1 of the criteria in paragraph (2) is met. The erroneous use of the term "deprivation" is also removed and replaced with "restriction".

Article 56 amending Article 41

Article 56 substitutes the incorrect wording of "deprivation" [of liberty] in Article 41 with the correct wording of "restriction" [on liberty] in instances where it occurs.

Article 57 amending Article 44

Article 44 sets out the manner in which an assessment if carried out by assessors in order to determine whether to recommend to the Minister that a standard SRoL authorisation be granted.

Article 57 replaces the requirement for the assessor to either be a registered medical practitioner or to interview a registered medical practitioner who has seen P immediately before the assessment and also corrects the wording describing the purpose of the involvement of a medical practitioner. That purpose is to provide confirmation that P suffers from an impairment or disturbance in the functioning of their mind or brain, rather than (as incorrectly stated at present) to provide confirmation that P lacks capacity, which it is the assessor's role to determine. The assessor will now be able to use medical evidence which could be obtained through either: (i) consulting a medical practitioner who has assessed P, or (ii) obtaining a written opinion given by a medical practitioner in the preceding 12 months, provided the assessor is satisfied that that opinion remains accurate.

Article 58 substitutes a new Article 48 into the Capacity Law

The new Article 48 that is substituted into the Mental Health by the draft Law has been expanded and now operates to extend any existing standard SRoL authorisation, which is in place on the date the draft Amendment Law commences, to include measures which are forms of restraint which have not, until the change to Article 9 made by the Amendment Law, fallen within the definition of restraint but which have nonetheless been recommended in the Capacity and Liberty Assessor's report which led to that authorisation. The transitional provisions are constructed so that no further assessment is required and without any further notification of authorisation being issued by the Minister. They essentially enable amendments to Article 9(2) to take effect without requiring the reauthorisation of a large proportion of current SRoLs.

Article 59 amending Article 55

Article 59 amends Article 55 to clarify and place beyond doubt that the Law allows for 1 application for a review of those restraint recommendations during the period for which the standard authorization remains in effect.

Article 60 amending Article 59

Article 60 corrects an error in Article 59 of the Capacity Law, by changing "and" to "or" so that paragraph (2) uses the same terminology (health or safety) as is found in paragraph (1) of Article 59.

Article 61 amending Article 72

Article 61 corrects an error in Article 72 of the Capacity Law, which appeared to repeal any Jersey customary law concerning curatelles. However, there was no need to repeal customary law relating to curatelles as it was repealed by Article 50 of the 1969 Law. The policy intention had been to repeal any existing customary law rules relating to curatorships. Curatelle and curators are separate legal concepts.

Article 62 introduces Schedule 2 of the draft Law that contains amendments consequential to Part 2.

Article 50 introduces Schedule 2 which contains amendments to other legislation. These amendments replace outdated references to curators with references to delegates appointed under the Capacity Law.

Financial and staffing implications

The resources required to develop and bring forward the necessary supporting amendment Orders and to amend both the Mental Health (Jersey) Law 2016 Code of Practice and the Capacity and Self-Determination (Jersey) Law 2016 will be found within existing departmental allocations. Any training required as a result of amendments made by the draft Law will also be delivered from within existing departmental budget allocations.

The draft Law does not make any amendments to the grounds on which patients are admitted into Mental Health Services as such it is not expected that admission rates will change as a result of these amendments.

The amendments proposed by the draft Law make amendments to the legislation that underpins existing processes, clarifies current provisions or corrects previous errors and oversights in legislation. It is not envisaged that any of these amendments will result in significant additional costs for Mental Health Services.

Children's Rights Impact Assessment

A Children's Rights Impact Assessment (CRIA) has been prepared in relation to this proposition and is available to read on the States Assembly Website.

Human Rights

The notes on the human rights aspects of the draft Law in the Appendix have been prepared by the Law Officers' Department and are included for the information of States Members. They are not, and should not be taken as, legal advice.

APPENDIX TO REPORT

Human rights notes on the Draft Mental Health, Capacity and Self-Determination (Jersey) Amendment Law 202-

These notes have been prepared in respect of the Draft Mental Health, Capacity and Self-Determination (Jersey) Amendment Law 202- (the "draft Law") by the Law Officers' Department. They summarise the principal human rights issues arising from the contents of the draft Law and explain why, in the Law Officers' opinion, the draft Law, in the form reviewed by them, is compatible with the European Convention on Human Rights ("ECHR").

These notes are included for the information of States Members. They are not, and should not be taken as, legal advice.

The draft Law would, if adopted, amend the Mental Health (Jersey) Law 2016 (the "MHL") to alter the terminology or clarify the description of various individuals covered by its provisions, to alter the individuals to whom duties apply, who must be consulted, who must provide certification or evidence, who can make communication restriction requests, who must receive notice of a decision to withhold a patient's postal item and who are given a right to apply for review of a decision to withhold to the Mental Health Review Tribunal (the "Tribunal"). Substantive amendments are made to Article 22 MHL (treatment authorization) so that the grounds for renewing a treatment authorization mirror the grounds for the original admission of the patient for treatment; (b) to Article 84 MHL (review of restrictions, and offence where restriction unlawful) to place an obligation on the Tribunal when reviewing a decision to determine whether the grounds justifying the decision to withhold a postal item or restrict communication continue to exist. The amendments also update words and phrases and make housekeeping amendments in line with current drafting style.

The draft Law, if passed, would also make amendments to the Capacity and Self-Determination (Jersey) Law 2016 (the "CSDL"). The type of behaviour that constitutes restraint under Article 9 CSDL (certain acts of restraint etc. which are not permitted) is widened and provision that is necessary because of that change is added to the Minister's standard authorization regime in Article 48 CSDL. A reference in Article 34 CSDL (general provisions concerning delegates) to a delegate's resignation triggering the end of delegate's appointment is removed. The definition of "relevant place" for Part 5 CSDL is clarified. Substantive changes to the process to assess a lack of capacity in Article 44 CSDL (manner of assessment) are made, including providing 2 routes to obtain the medical evidence required for an assessment in relation to significant restrictions on liberty. In addition to these substantive changes, the amendments correct drafting errors and update words and phrases throughout the CDSL.

Both the MHL and CSDL were assessed as compatible with the ECHR when those Laws were lodged as draft Laws in 2016 (referenced in this memorandum as the "original compatibility assessment", respectively as the case applies). The propositions for each draft Law[1] contain the applicable human rights notes provided by LOD.

The following sections of this note provide an assessment of the ECHR compatibility of those amendments to the MHL and CSDL that would be made by the draft Law that are considered to be substantively material or notable. Provisions of the draft Law that are not referenced in this note are not considered to raise any substantively material compatibility issues.

[1] Draft Mental Health (Jersey) Law 201- (P.78/2016); draft Capacity and Self-Determination (Jersey) Law 201- (P.79/2016).

Amendments to the Mental Health (Jersey) Law 2016

Amendment to Article 15 (emergency admissions)

Article 15 MHL provides an emergency admission power, permitting the detention of a person in an approved establishment for a limited time if they are assessed to be suffering from a mental disorder and where it is considered that allowing the patient to remain at liberty would endanger their safety or the safety of other people. Article 11 of the draft Law would substitute, for the current Article 15 MHL, a new version of that provision. The new Article 15 MHL makes substantive amendments to the provision, by changing the class of the practitioner who may authorize emergency detention, requiring those practitioners to be either an approved clinician or a registered medical practitioner with the experience specified in new Article 15(2) MHL.

In ECHR terms, the detention of mentally disordered persons engages the right to liberty under Article 5 ECHR. Article 5(1)(e) ECHR permits the detention of persons of unsound mind in accordance with a procedure prescribed by law. However, the emergency detention of persons, such as under new Article 15 MHL, is compatible with Article 5 ECHR because the full procedural safeguards required by the ECHR are not required in emergency situations[2] such as those arising in the context of an Article 15 MHL detention, nor where the detention might be for a negligible period. This same assessment of compatibility of the Article 15 MHL power was set out in the original compatibility assessment, and that compatibility assessment is not affected by the amendments to be made by Article 11 of the draft Law.

Amendment to Article 22 (treatment authorization)

Article 22 MHL makes provision for the authorization of the admission of a person to an approved establishment for the treatment of a mental condition. Article 22(1) MHL sets out the legal test for an application for admission to be authorized by the Minister. The duration of a treatment authorization is 6 months from the date of admission (Article 22(2)(a) MHL) and must then be renewed.

Article 22(3) and (4) MHL provide for the renewal of a treatment authorization. Article 22(4) MHL requires that the Responsible Medical Officer (this will be amended by the draft Law to the 'Responsible Clinician') must, within the period of 2 months immediately preceding the day on which the patient's liability to detention ceases, examine the patient and make a report to the Minister recommending either the renewal of the authorization or that the authorization should not be renewed. The test under Article 22(4) MHL for renewal of an authorization is that it is necessary in the interests of the patient's health or safety, or for the protection of other persons. The renewal test does not, however, currently require that it be shown that the patient continues to suffer from mental disorder of a nature or degree which warrants detention for treatment. In contrast, such a requirement is stated in the test for the initial authorization of detention (see Article 22(1)(a) MHL).

Article 14 of the draft Law would amend Article 22 MHL to address this by, inter alia, inserting a new Article 22(4)(a)(i) that would permit the renewal of a treatment authorization only if it is shown that the patient continues to be suffering from mental disorder of a nature or degree that warrants the detention of the patient in an approved establishment.

Article 22 MHL engages the right to liberty in Article 5 ECHR because it permits the compulsory detention and deprivation of the liberty of a person suffering from a mental disorder. Article 22 MHL was assessed to be compatible with Article 5 ECHR in the original compatibility assessment. The amendments that would be made to Article 22 MHL by the draft Law do not affect that assessment of compatibility. Rather, the amendments are considered to be rights-enhancing. Article 5(1)(e) ECHR permits the detention of persons of an unsound mind, but an

[2] *Winterwerp v Netherlands* (1979) 2 EHRR 387, para 39.

individual cannot be deprived of his liberty as being of 'unsound mind' unless the mental disorder is of a kind or degree to warrant compulsory confinement. The validity of continued confinement depends, therefore, upon the persistence of such a disorder[3]. The amendment at new Article 22(4)(a)(i) will ensure that, at the point of renewal of an authorization, the basis for the continued detention of the patient includes the existence of a mental disorder that warrants the detention. On this reasoning, Article 14 of the draft Law, and the amendments it would make to Article 22 MHL, are considered to be compatible with Article 5 ECHR.

Amendment to Article 41 (treatment requiring either consent or a second opinion)

Article 41 MHL permits certain specified treatment (see Article 41(2) MHL) to be administered to a patient either with the patient's consent and a certificate issued by a specified practitioner (the patient's responsible medical officer, or another approved practitioner), or on the certificate of a second opinion approved doctor ("SOAD") only, i.e. without the consent of the patient. The certificate provided by a specified practitioner must state that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment and has consented to receive it.

An individual's right to refuse medical treatment falls within the scope of the right to private life in Article 8 ECHR. A medical intervention in defiance of the subject's will, or without consent, will give rise to an interference with the right to respect for private life, in particular the right to physical integrity[4], which must then be justified under Article 8(2) ECHR if it is to be compatible. Article 41 MHL engages the right to private life under Article 8 ECHR, especially in those cases where the treatment is administered to a patient without the patient's consent on the opinion of a SOAD. Article 41 MHL was assessed to be compatible with Article 8 ECHR as detailed in the original compatibility assessment.

Article 17 of the draft Law would amend Article 41 MHL to, inter alia, provide that, in addition to the certificate provided by the approved clinician in charge of treatment to be given to the patient or an approved clinician who is a registered medical practitioner (the draft Law would substitute this description of the relevant practitioners involved from those that appear in the current Article 41 - see current Article 41(1)(a) MHL as amended by new Article 41(1)(a)(i) and (ii)), a SOAD may also provide a certificate that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment and has consented to receive it. The expansion of the list of persons who may provide the requisite certificate in Article 41(1) MHL, to include a SOAD, is to allow for the occasional case where a patient who has previously declined to give consent to medication has changed their mind, and given their consent, during discussion with the SOAD. This amendment raises no Article 8 ECHR compatibility issues of itself and does not alter the Article 8 ECHR compatibility assessment of Article 41 MHL as provided in the original compatibility assessment.

Amendments to Articles containing provisions relating to criminal offences and penalties

The draft Law would make amendments to various provisions in the MHL which make provision for criminal offences and penalties. The amended provisions are Article 73 MHL (offence of wilful neglect), Article 74 MHL (sexual offences: prohibited acts), Article 75 MHL (sexual offences: relationship of care), Article 76 MHL (sexual offences: coercion), Article 77 MHL (sexual offences: penalties), Article 80 MHL (offences: forgery and false statements), Article 84 MHL (review of restrictions and offence where restriction is unlawful), Article 91 MHL (offence of assisting person to abscond), Article 92 (offence of obstruction), and Schedule, Part 1,

[3] See *Winterwerp* (1979–80) 2 E.H.R.R. 387 at [39]; *Johnson* (1999) 27 E.H.R.R. 296 at [60]; and *Varbanov v Bulgaria* (31365/96) October 5, 2010 at [45].
[4] *X v Finland*, Application no. 34806/04.

paragraph 6 (offence of disclosure of information) (together, the "relevant criminal offences"). The amendments are made by Articles 32 – 37, 40 – 42 and 45 of the draft Law.

The relevant criminal offences appear currently in the MHL and were assessed to be compatible with the ECHR in the original compatibility assessment. The amendments to these provisions do not create any new criminal offences or penalties. The amendments to the relevant criminal offences are required to reflect updated drafting style and do not substantively alter the formulation or effect of the offence provision in each case. There are also no amendments to the criminal penalties for these offence provisions.

Article 7 ECHR is engaged by the amendments in so far as Article 7 ECHR requires that criminal offences and corresponding penalties are clearly defined in law. The elements of the relevant criminal offences would, if amended by the draft Law, continue to be set out in a way that is clear and comprehensible, such that the public would have a good understanding of what it means to carry out the various conduct which is covered by the offences. The amendments to the relevant criminal offences do not, therefore, raise any compatibility issues in Article 7 ECHR terms.

Amendments to provisions relating to restrictions on electronic media and communications and postal packets

Article 38 and 39 of the draft Law would make amendments to Article 82 MHL (restrictions on access to electronic media and communications etc) and Article 83 MHL (restrictions on postal correspondence), respectively.

The amendments to Article 82 MHL would, inter alia, clarify that any restriction must not be imposed unless the necessary grounds as set out in new Article 82(1A)(a) or (b) have been met; broaden the list of persons (to include a Responsible Clinician) who may be notified by a potential recipient of communications that they wish a restriction to be imposed on a patient; and remove, as unnecessary, a requirement for the managers to give formal notice of the imposition of a restriction of a patient's ability to contact a specified person to the person who requested that the restriction be imposed.

The amendments to Article 83 MHL would clarify, through improvements to drafting, that a restriction must not be imposed unless the grounds as set out in Article 83(1A)(a) or (b) are met; and clarify who must be provided, in writing, with notice of a restriction and therefore has a right to review under Article 84 MHL. The Article, in its current form, does not state that a person who has sent a postal item to a patient, which is then withheld from the patient, should be given notice and have a right of review. The amendment will make it clear that notice must be given to the sender of incoming post which is withheld from the patient, the addressee of outgoing post which is withheld from dispatch, and the patient in either case.

Article 82 and 83 MHL engage Article 8 ECHR, as the restrictions provided for in those provisions would interfere with the right to privacy of patients as guaranteed by Article 8 ECHR. Article 82 and 83 MHL were assessed to be compatible with the ECHR in the original compatibility assessment in respect of the MHL. The amendments made by Articles 38 and 39 of the draft Law do not make any substantive changes to the effect of those provisions that would materially alter the compatibility assessment of those provisions. The amendments clarify the application of the restrictions involved and enhance the Article 8 ECHR rights of patients and persons with whom and by whom communications are exchanged or intended for. As such, the amendments made by Article 38 and 39 are considered to be compatible with Article 8 ECHR.

Amendments to the Capacity and Self-Determination (Jersey) Law 2016

Amendment to Article 9 (certain acts of restraint etc. which are not permitted) and Article 48 (standard authorizations)

Part 5 of the CSDL contains provisions relating to the imposition of significant restrictions on the liberty ("SROL") of individuals ("P") who are assessed to have lost capacity and who are cared for in a "relevant place". A "relevant place" means, essentially, a hospital or a care setting (see Article 37, as it would be amended by Article 54 of the draft Law). Part 5 of the CSDL requires the Minister to issue an authorization, on a standard or urgent basis, for the lawful imposition of an SROL on P.

Article 39 CSDL sets out those measures that amount to an SROL if applied to P on a regular basis. The measures include, at Article 39(2)(d), where P's actions are controlled, whether or not in the relevant place, by the application of physical force or of "restraint as defined in Article 9(2)". The effect of this is that if a person in a relevant place is restrained within the meaning given by Article 9(2) CSDL that measure would constitute an SROL under Article 39 CSDL. The imposition of that SROL would be required to be authorized by the Minister in accordance with the provisions of Part 5 CSDL.

Article 9 CSDL provides that a person (in connection with the care and treatment of another person, "P") restrains P if they use, or threaten to use, force to secure the doing of an act which P resists, and restricts P's liberty of movement, whether or not P resists or objects to the restriction. The conjunction 'and' is emphasised here because, for the purposes for the CSDL as currently drafted, P is not restrained by another person unless both limbs of the test in Article 9(2) CSDL are met - P must be both subject to the threat or use of force and have their liberty of movement restricted in some way to be 'restrained'. The effect of this in practice is that the use of measures such as the administration of sedative or psychotropic medication (sometimes called 'chemical restraint'), or the use of bedrails, alone does not constitute restraint for the purposes of the CSDL. The use of the conjunction 'and' is a drafting issue in Article 9(2) CSDL which has been present since its enactment. The policy intent for the test of restraint in Article 9(2) CSDL is that it should only require either (a) or (b) to be established, not both elements.

The drafting issue in Article 9(2) CSDL is to be remedied by Article 52 of the draft Law, which would substitute the conjunction 'or' in place of 'and' where it appears at the end of sub-paragraph (a). The effect of this amendment would be that, for the purposes of Article 9(2) CSDL, a person is restrained if they are subject to the use, or threat of use of, force to secure the doing of an act which they resist, or have their liberty of movement restricted.

Restrictions on the liberty of a person will engage Article 5 ECHR, the right to liberty and security. It is useful for the purposes of this note to restate some relevant principles of Article 5 ECHR in this context. Article 5 ECHR is not concerned with mere restrictions on liberty of movement[5], and the difference between restrictions on movement that are serious enough to fall within the ambit of deprivation of liberty under Article 5 ECHR and mere restrictions of liberty is one of degree or intensity, not one of nature or substance[6]. In the case of Storck[7] the European Court of Human Rights ("**ECtHR**") has confirmed that a deprivation of liberty for the purposes of Article 5(1) ECHR has three elements:

a) the objective element of confinement in a restricted space for a non-negligible period of time;

b) the subjective element that the person has not validly consented to that confinement; and

c) the detention being imputable to the state.

[5] *Creanga v Romania* [GC], no.29226/03, 23 February 2012*; Engel and Others v the Netherlands*, 8 June 1976, Series A no.22.

[6] *Guzzardi v Italy,* 6 November 1980, Series A no.39; *Rantsev v Cyprus and Russia*, no.25965/04, ECHR 2010; *Stanev v Bulgaria*, [GC], no.36760, 17 January 2012.

[7] Storck v Germany (2006) 43 EHRR 6 at [74].

Article 5(1) ECHR permits a deprivation of liberty in specific cases, and where that deprivation is lawful and in accordance with a procedure prescribed by law[8]. One such case is the lawful detention of persons of unsound mind (Article 5(1)(e) ECHR). An individual cannot be deprived of his liberty as being of 'unsound mind' unless the following three minimum conditions are satisfied[9] -

a) The individual must be reliably shown, by objective medical expertise, to be of unsound mind, unless emergency detention is required;

b) The individual's mental disorder must be of a kind to warrant compulsory confinement. The deprivation of liberty must be shown to have been necessary in the circumstances;

c) The mental disorder, verified by objective medical evidence, must persist throughout the period of detention.

Article 5 ECHR requires that any person deprived of his liberty on the ground that he is of unsound mind, should be detained in a hospital, clinic or other appropriate institution[10]. The state is granted a margin of appreciation in securing compliance with Article 5 ECHR[11].

Article 9 CSDL was assessed to be compatible with Article 5 ECHR when the CSDL was proposed as a draft Law in 2016 - see the original compatibility assessment in respect of the CSDL. That assessment of compatibility is not affected by the amendment to Article 9(2) CSDL that would be made by Article 52 of the draft Law. The original assessment of compatibility for Article 9 CSDL considered that a restraint measure, when used on an emergency basis, would likely not constitute a violation of Article 5 ECHR. Moreover, when a restraint measure is used on a temporary or infrequent basis, it would likely not be applied to the requisite degree to constitute a deprivation of liberty for the purposes of Article 5 ECHR.

Where, however, restraint is applied to an individual on a regular basis such that the degree of its use would amount to a deprivation of liberty for the purposes of Article 5 ECHR, that deprivation of liberty is lawful in ECHR terms only if it comes within one of the specified cases permitted under Article 5 ECHR and is in accordance with a procedure prescribed by law. Part 5 CSDL sets out the framework for the authorization by the Minister of SROLs. The provisions of Part 5 CSDL were assessed to be compatible with Article 5 ECHR in the original compatibility assessment in respect of the CSDL.

A feature of the Part 5 CSDL framework is Article 48 CSDL which sets out the process by which the Minister may issue a standard authorization for the imposition of an SROL. Briefly, Article 48 CSDL permits the Minister to issue a standard authorization where P has been subject to an assessment (which is an assessment of P's capacity and the proposed restrictions as an aspect of that person's care), and where a subsequent report has been provided to the Minister by the assessor which assesses in the affirmative that an SROL is in P's best interests and is necessary. A standard authorization for an SROL may be imposed for a period of no more than 12 months, and must be renewed in accordance with the CSDL thereafter.

Article 58 of the draft Law would substitute a new Article 48 CSDL for the existing provision. The provisions in new Article 48(1) – (8) are a reformulated version of the provisions in the current Article 48(1) – (5) CSDL, and have been updated primarily to reflect current drafting style. The reformulation of the existing Article 48 CSDL in this way does not substantively alter the effect of the provision. As such, the substituted provisions are compatible with Article 5 ECHR, for the reasons noted in the original compatibility assessment.

[8] *Winterwerp v Netherlands* (1979) 2 EHRR 387 (para 39).
[9] *Stanev v Bulgaria* [GC], no.36760, 17 January 2012*; Varbanov v Bulgaria,* no.31365/96, ECHR 2000-X*; Shtukaturov v Russia,* no.44009/05, ECHR 2008*; Winterwerp v the Netherlands,* 24 October 1979, Series A no.33.
[10] *Ashingdane v United Kingdom*, (1985) 7 EHRR 528, para 44.
[11] *Weeks v United Kingdom* (1987) 10 EHRR 293 (para 50); *Winterwerp v Netherlands* (1979) 2 EHRR 387 (para 40).

The substituted Article 48 would also introduce new provisions in sub-paragraphs (9) – (12). These provisions are designed to address a transitional issue that would arise from the cumulative effect of the amendment to Article 9(2) CSDL (as discussed above) and the requirement under Part 5 CSDL that SROL measures involving restraint, within the meaning of Article 9(2) CSDL, must be authorized by the Minister.

The effect of the drafting issue in Article 9(2) CSDL discussed above – the use of the conjunction 'and' rather than 'or' in that provision – has meant that a person who, as part of their care arrangements, has been subject to either the use or threat of force, or has had their liberty of movement restricted in some way, has not been deemed in law to have been 'restrained' for the purposes of Article 9(2) CSDL. Consequently, because that person is not 'restrained' for the purposes of Article 9(2) CSDL, the restraint measure does not come within the scope of measures identified as an SROL in Article 39 CSDL, and so is not required to be authorized under Part 5 CSDL.

In view of, and in spite of this, capacity and liberty assessors ("CLAs"), whose function it is to undertake the assessments of individuals in care for the imposition of SROLs under Part 5 CSDL, have adopted a policy-led approach when undertaking assessments of restraint measures. This approach has involved CLAs identifying and assessing measures that would, but for the drafting issue in Article 9(2) CSDL, be restraint for the purposes of Article 9(2) CSDL as it is intended to apply, and have then assessed and reported on those measures for their necessity, proportionality and as to whether the measure is in the person's best interests.

The effect of the amendment to Article 9(2) CSDL – changing the conjunction 'and' to 'or' - would be to bring within the scope of the SROLs listed in Article 39 CSDL, and specifically Article 39(2)(d), a person who is subject to a measure that involves either a threat or use of force, or one that restricts their liberty of movement. The amendment, when made, would render those individuals in care who, prior to the amendment taking effect were subject to restraint measures that did not require authorization under Part 5 CSDL, being deemed subject to restraint measures that require authorization. The practical consequence of this is that all current SROL cases where such restraint measures apply would require immediate re-assessment so that the measure could be formally authorized. This would require a significant proportion of current SROL authorisations to be re-assessed and re-authorized. If, however, those measures are not authorized, their imposition in practice would be contrary to the CSDL. To continue to apply a restraint measure, a deprivation of liberty in ECHR terms, in this way without authorization would likely also be incompatible with Article 5 ECHR.

The provisions in new Article 48(9) – (12) (the "transitional provisions") would address this issue. In overview, at the point at which the amendment to Article 9(2) CSDL is made, the intention is that the transitional provisions would deem pre-existing restraint measures assessed in accordance with Article 45 CSDL to be authorized under Part 5 CSDL. This remedial mechanism would apply only to those cases in which a CLA had already provided a report under Article 45 CSDL which contained a recommendation for the application of a restraint, defined as a 'recommended restraint' (see new Article 48(9)). 'Restraint' here means, as defined in new Article 48(11), a restraint within the meaning of Article 9(2) CSDL, as it would be amended by Article 52 of the draft Law – that is to say, either a measure involving either the threat or use of force, or a measure involving a restriction on the liberty of movement of an individual.

New Article 48(10) is the provision that would provide the authorization for the recommended restraint measures. It would provide that, from the commencement of the draft Law only, a recommended restraint is taken to be authorized by the standard authorization issued by the Minister in respect of that person. In other words, at the point at which, with the amendment to Article 9(2) CSDL, it would become legally necessary to authorize the restraint measures which are applied to a person, the CSDL would operate to deem the existing standard authorization as extending to cover the recommended restraints, thereby providing a lawful basis for their imposition going forward.

It should be noted that the transitional provisions would expire 12 months after the date of the draft Law's registration (see new Article 48(12)). The reason for applying an expiry period of 12 months for these provisions is because the maximum duration of a standard authorization, before it must be renewed under Part 5 CSDL, is 12 months (see Article 48(2) CSDL). As such, within a period of 12 months from the date of registration of the draft Law, any pre-existing standard authorizations, to which it is necessary for the transitional provisions to apply, will have either run their course and expired, or will have been renewed in accordance with Part 5 CSDL if there is a necessity for the restraint measure to continue to be applied. For this reason, the remedial effect of the transitional provisions will be redundant at the 12 month post-registration mark, and so the draft Law makes provision for those provisions to expire at that point.

An important safeguard also exists in new Article 48(10)(a). It provides that a standard authorization given further to a CLAs report before the commencement of the draft Law, for the avoidance of doubt, is not to be taken to have authorized a recommended restraint. In effect, this means that a pre-existing standard authorization issued under Article 48 CSDL is not to be taken as authorization for recommended restraints in their application before the commencement of the draft Law. This provision is important as its effect is to prevent the retrospective authorization of restraint measures in their application before the commencement of the draft Law. This ensures that the remedial, cumulative effect of the amendment to Article 9(2) CSDL and the transitional provisions is prospective only.

The wider provisions of Part 5 CSDL were assessed to be compatible with Article 5 ECHR in the original compatibility assessment in respect of the CSDL. It is not necessary for the purposes of this note to revisit the compatibility assessment of those provisions, except to note that the assessment of Article 5 ECHR compatibility included the current Article 48 CSDL. The new substituted Article 48(1) – (8), which is a reformulated version of the existing Article 48 CSDL but with no substantive alterations, raises no issues from an Article 5 ECHR perspective.

The transitional provisions will engage Article 5 ECHR because their effect, within the framework of Part 5 CSDL, is to permit in legal terms the imposition of a deprivation of liberty, in the form of restraint, on individuals subject to a pre-existing standard authorization. Compliance with Article 5 ECHR requires the identification of substantive and procedural rules to which the deprivation must conform[12]. The requirement for 'lawfulness' under Article 5 ECHR is not satisfied merely by demonstrating that the imposition of a significant restriction on P's liberty was lawful under the provisions in Part 5 CSDL, but must be in conformity with the ECHR, including the general principles implied in Article 5(1) ECHR case law[13], that the lawful basis for a deprivation of liberty must be sufficiently certain and protect against arbitrary detention[14].

Taking these in turn, legal certainty requires the conditions for a deprivation of liberty under domestic law to be clearly defined and that the law itself must be foreseeable in its application so that it meets the standard of 'lawfulness' set by the ECHR. That standard requires all law to be sufficiently precise to allow the person to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action may entail[15]. The wider provisions of Part 5 CSDL continue to meet this requirement, as set out in the original compatibility assessment. The transitional provisions are clearly drafted and their application can be readily understood. The effect of the amended Article 9(2) CSDL and the transitional provisions, within the framework of Part 5 CSDL, will also be foreseeable to those subject to its provisions. In this regard, the provision at new Article 48(10)(a), which makes it clear that the transitional provisions do not have retrospective application, is important. It gives the transitional provisions a prospective application only, and means the provision is foreseeable to those who would be

[12] *Del Rio Prada v Spain* [GC], no.42750/09, ECHR 2013.
[13] *Pleso v Hungary*, no.41242/08, 2 October 2012.
[14] *Simons v Belgium* (dec.), no.71407/10, 28 August 2012.
[15] *Del Rio Prada v Spain* [GC], no.42750/09, ECHR 2013; *Creanga v Romania* [GC], no.29226/03, 23 February 2012*; Medvedyev and Others v France* [GC], no.3394/03, ECHR 2010.

subject to its application, ensuring compatibility with the principle of legal certainty under Article 5 ECHR.

Existing features in Part 5 CSDL that protect against the arbitrary deprivation of a person's liberty will continue to apply to persons subject to the transitional provisions. At their core is the requirement that the transitional provisions can apply only if a person has been the subject of an Article 45 CSDL report by a CLA, issued before the commencement of the draft Law, which contained recommendations for the application of restraint (see new Article 48(9)); and the effect of new Article 48(10) which is to provide a legal authorization for the imposition of those restraints.

To comply with Article 5 ECHR, an assessment for the purpose of determining whether someone may be deprived of his liberty must take appropriate account of the views and wishes of the person and his family[16]. A person subject to the transitional provisions would have been subject to a full assessment under Article 44 CSDL – because the Article 45 CSDL report referred to in new Article 48(9) can only be prepared following that assessment. That assessment requires one or more interviews with P and other specified persons (Article 44(2) to (5) CSDL) such as P's guardian or nearest relative, and the report on the assessment must identify those persons whose views have been considered and must summarize those views (Article 45(2)(d) CSDL).

Moreover, to protect against arbitrary detention it is also imperative that, in the case of the detention of a person of unsound mind pursuant to Article 5(1)(e) ECHR, there is medical evidence establishing that the person's mental state is such as to justify his detention[17]. No deprivation of liberty of a person considered to be of unsound mind may be deemed in conformity with Article 5(1)(e) ECHR if it has been ordered without seeking the opinion of a medical expert[18]. A person subject to the transitional provisions will have been subject to an assessment under Article 44 CSDL, further to which a report will have been issued under Article 45 CSDL recommending restraint (see new Article 48(9)). That assessment will have either been carried out by a registered medical practitioner or will have involved an interview with a registered medical practitioner, thereby ensuring the requisite medical opinion on the individual can form part of the basis for the person's deprivation of liberty.

For a deprivation of liberty not to be arbitrary there must be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention[19]. Where Article 5(1)(e) ECHR applies, the detention of a person for reasons relating to his mental health should take place in a hospital, clinic or other appropriate institution[20]. A person subject to the transitional provisions will be subject to a standard authorization already issued by the Minister under Article 48 CSDL, and that authorization will authorize the application of SROLs in the 'relevant place' where the person's care is provided (the manager of the relevant place is responsible for making an application for an SROL assessment to be performed – see Article 43 CSDL). A 'relevant place' is defined in Article 37(3) CSDL and means a hospital, approved care home, premises on which the conditions of a person's registration under the Regulation of Care (Jersey) Law 2014 permit them to carry on a regulated activity, and an establishment designated by the Minister for the purposes of providing health or social care, or both health and social care. As such, a person subject to the transitional provisions will continue to be subject to a deprivation of their liberty in an appropriate institution, in a manner compatible with Article 5 ECHR.

The requirement that detention not be arbitrary also implies the need for a relationship of proportionality between the ground of detention relied upon and the detention in question. The scope of the proportionality test to be applied in a given case varies depending on the type of

[16] *Hillingdon London Borough Council v Neary* [2011] 4 All ER 584.
[17] *Winterwerp v Netherlands* (1979–80) 2 E.H.R.R. 387 *at [39]*.
[18] *Ruiz Rivera v Switzerland*, no.8300/06, 18 February 2014; *SR v the Netherlands* (dec.), no.13837/07, 18 September 2012.
[19] Saadi v United Kingdom (2008) 47 E.H.R.R. 17 at [69].
[20] *Aerts v Belgium* (2000) 29 E.H.R.R. 50 at [46]; and *Brand v Netherlands* (49902/99) May 11, 2004 at [62].

detention involved. An individual cannot be deprived of his liberty as being of "unsound mind" unless the mental disorder is of a kind or degree, or necessary, to warrant compulsory confinement, and the validity of continued confinement depends upon the persistence of such a disorder[21] (i.e. together with the requirement for medical evidence, the Winterwerp criteria). The detention of a person may be 'necessary' where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons[22].

The transitional provisions, taken together with the broader procedures set out in Part 5 CSDL, would satisfy requirements for protection against arbitrariness and proportionality, and in turn the Winterwerp criteria. The authorization process set out in Part 5 CSDL requires those assessing an individual to consider the proportionality of any significant restrictions for the individual concerned. For instance, an assessment of P must enable the assessor to form a view as to whether it is necessary to impose a significant restriction on P's liberty in the interests of P's health or safety (Article 44(6)(b) CSDL). In addition, where a standard authorization is in place, the manager is required to keep under review the necessity to maintain the SROLs that have been authorized (Article 53 CSDL). The manager must cease to impose the restrictions if P regains capacity or where those restrictions are no longer in P's best interests or necessary in the interests of P's health or safety. A person subject to the transitional provisions will be subject to a standard authorization issued under Article 48 CSDL, which will have been issued further to an assessment of the individual under Article 44 CSDL. The existing safeguards in the CSDL against arbitrariness, and those that ensure proportionality in SROL measures, will continue to apply to the person subject to the transitional provisions.

In conclusion, for the reasons stated above, it is considered that the amendments to Article 48 CSDL to be made by Article 54 of the draft Law are compatible with Article 5 ECHR.

Amendment to Article 44 (manner of assessment)

Part 5 CSDL provides, inter alia, a procedure for CLAs to perform an assessment of P in order for a report to be provided to the Minister confirming, inter alia, whether it is necessary to impose, as a component of P's care or treatment, an SROL on P's liberty in the interests of P's health or safety (see Article 44(6) CSL). The CSDL requires (see Article 44(2) CSDL) that the CLA's assessment is carried out by means of one or more interviews with P; and in any case where either the assessor is not a registered medical practitioner, or there is no medical evidence of P's lack of capacity at the date of the assessment, with a registered medical practitioner who has seen P immediately before the assessment.

The application of Article 44 CSDL in practice has, from an operational perspective, proven to be problematic for several reasons, and the draft Law would amend Article 44 CSDL to remedy these issues. Among the issues addressed by the draft Law is the requirement in Article 44(2) CSDL that the assessment of P is performed by means of one or more interviews with P and (per Article 44(2)(b)(ii)) by an interview with a registered medical practitioner who has seen P immediately before the assessment in cases where "there is no medical evidence of P's lack of capacity[23] at the date of the assessment".

In a case where there is no medical evidence at the date of assessment available, Article 44(2)(b) requires the CLA to interview a registered medical practitioner, and in turn that practitioner would have been required to have seen P immediately before the CLAs assessment. In these cases then, where there is no recently documented medical evidence available, the CSDL imposes a

[21] See *Winterwerp* (1979–80) 2 E.H.R.R. 387 at [39]; Johnson (1999) 27 E.H.R.R. 296 at [60]; and *Varbanov v Bulgaria* (31365/96) October 5, 2010 at [45].
[22] *Hutchinson Reid v the United Kingdom*, no.50272/99, ECHR 2003-IV.
[23] The reference to "medical evidence of P's lack of capacity" is also subject to an amendment by the draft Law because it is incorrect to refer to 'medical evidence' of a lack of capacity. The test for a lack of capacity is based not only on medical evidence but on other functional and cognitive matters.

requirement for P to have been examined by a registered medical practitioner before the CLA's assessment.

A practical issue presented by these provisions is that, in some cases, the intended SROL is one which is proposed to have a limited duration, or the SROL is being considered for a person who has a medical condition which has been diagnosed some time ago and is a condition from which the person will not recover (e.g. dementia). The application of Article 44(2) CSDL in practice has, in all cases, resulted in a medical examination of P by a registered medical practitioner in addition to the interview of P carried out by the CLA under Article 44(2)(a) CSDL. In policy and clinical terms, the concern with this practice is that the medical examination of persons affected by irreversible medical conditions for which have already been clearly diagnosed and/or for whom a short term SROL is being considered would constitute a disproportionate interference with their rights or have an unnecessary detrimental impact on their wellbeing. In the case of conditions such as dementia, there would be negligible, if any, development in P's condition which could usefully be examined and reported on by a registered medical practitioner.

In policy terms, it is considered that reduced involvement of registered medical practitioners in these cases would be an appropriate alternative to the current approach to SROL assessments. It is noted that under the Deprivation of Liberty framework in the Mental Capacity Act 2005 (the "MCA") there is no requirement for the supervisory body (i.e. the relevant local authority body approving the deprivation of liberty ("DoL") in question) to perform an assessment for the authorization of a DoL if several conditions are complied with. The conditions include that an existing assessment was carried out within the previous 12 months, and the supervisory body is satisfied that there is no reason why that existing assessment may no longer be accurate[24]. Moreover, proposed amendments to the MCA[25] would permit those making determinations on capacity and medical assessments to rely upon assessments carried out previously, including those prepared for another purpose, so long as it is reasonable to do so. The intention in the draft Law is that an existing assessment can be relied on by CLAs, provided it gives a reliable indication of the person's current situation.

Article 57 of the draft Law would amend Article 44 CSDL to make provision permitting the reliance on historic medical evidence in cases of established and irreversible conditions (e.g. dementia) for the purposes of the assessment under Article 44(2) CSDL. A consequence of this in practice in appropriate cases would be to avoid the necessity for P to be examined medically by a registered medical practitioner in addition to being interviewed by an assessor. New Article 44(2A) would provide that the medical evidence to be obtained by the CLA could be obtained by (i) consulting the registered medical practitioner who has assessed P immediately before the CLA's first interview with P; or (ii) by means of consulting a written copy of the opinion of a registered medical practitioner who assessed P in the 12-month period immediately before the CLA's first interview with P (the "previous opinion"). New Article 44(2B) would provide that the CLA can rely on the previous opinion only if satisfied that, at the time of the CLA's own assessment, the previous opinion continues to be accurate.

Included within this amendment is another fix to a practical issue with the current Article 44(2) CSDL. If amended by Article 57 of the draft Law, Article 44 CSDL would permit a CLA to rely on written medical evidence of P's condition (see new Article 44(2A)(b)), instead of having to conduct "interviews" with registered medical practitioners in order to obtain medical evidence. In England and Wales, the MCA 2005 permits those undertaking an assessment for DoL purposes to rely upon medical records rather than having to 'interview' the medical assessor on each occasion and enables consultation with written records of assessments.

The amendments to Article 44 CSDL to be made by Article 57 of the draft Law will engage Article 5 ECHR, the right to liberty, principally in respect of its amendment to the evidential basis

[24] Schedule A1, paragraph 49, Mental Capacity Act 2005.
[25] To be made by the Mental Capacity (Amendment) Act 2019, in new Schedule AA1, paragraph 21.

required in a CLA assessment. Article 5(1)(e) ECHR permits the lawful detention of persons of unsound mind in accordance with a procedure prescribed by law. For detention to comply with Article 5(1)(e) ECHR the person deprived of their liberty must be reliably shown by "objective medical expertise" to be of unsound mind[26]. The relevant time at which a person must be reliably established to be of "unsound mind", for the requirements of Article 5(1)(e) ECHR is the date of the adoption of the measure depriving that person of his liberty as a result of that condition[27]. Medical expert reports relied on by the authorities must therefore be sufficiently recent[28].

The amendments to Article 44 CSDL meet these procedural requirements. The necessity for objective medical expertise is met (as it is in the current version of Article 44 CSDL) by the requirement in new Article 44(2)(b) that the CLA carrying out the assessment obtains medical evidence that confirms that, at the date of the assessment, P suffers from an impairment or a disturbance in the functioning of their mind or brain. This procedural step ensures that the procedure for recommending an SROL takes account of objective medical evidence of the person's mental condition before any deprivation of liberty is authorized.

New Article 44(2A) will ensure that the medical evidence relied upon is sufficiently recent for Article 5(1)(e) ECHR purposes. The medical evidence may either be obtained at a point immediately before the CLA's first interview with P, or it may be obtained by reference to a written copy of the medical opinion provided in the 12-month period immediately before the CLA's first interview with P. In the former case, the medical opinion will be near-concurrent with the authorization of the SROL; in the latter case, a 12-month prior period to the CLA's interview is considered to be 'sufficiently recent' in principle. New Article 44(2B) will, however, ensure that active consideration is given by the CLA to whether a previous opinion continues to be accurate at the time of the CLA's assessment, and therefore could be relied upon in the assessment of P for SROL purposes. New Article 44 CSDL will, therefore, contain procedural steps that are, in principle, compatible with the evidential standards required under Article 5(1)(e) ECHR for depriving a person of unsound mind of their liberty.

Article 59 of the draft Law - Amendment to Article 55 (review of authorizations by tribunal) amended

Article 5(4) ECHR provides the right to a speedy judicial decision concerning the lawfulness of detention and ordering its termination, if it is proven to be unlawful. It entitles a detained person to bring proceedings for review by a court of the procedural and substantive conditions which are essential for the lawfulness of the deprivation of liberty[29]. The opportunity for review must be provided as soon after the person is taken into detention and thereafter at "reasonable intervals"[30]. A system of periodic review in which the initiative lies solely with the authorities is not sufficient on its own[31].

The CSDL provides that a person or his representative may make a request to the Tribunal for a review of an SROL authorization, and that request may be made as soon as the authorization is issued (Article 55(1) and (2) CSDL). This would enable a person subject to an SROL to make a request of his or her own initiative in an expeditious manner. Moreover, during each period of detention, which may be no longer than 12 months at a time (Article 48(2) CSDL), one application to the Tribunal may be made. Having regard to the maximum length of each authorization, this is considered a reasonable restriction. Decisions of the Tribunal may be appealed to the Royal Court under Article 58 CSDL.

[26] *Winterwerp v the Netherlands* 6301/73 [1979] ECHR 4.
[27] *M.B. v. Spain*, 2025, Application no. 38239/22; and others.
[28] *Kadusic v. Switzerland*, 2018, Application no.43977/13.
[29] *Idalov v Russia* [GC], no.5826/03, 22 May 2012 at 161; *Reinprecht v Austria*, no.67175/01, ECHR 2005-XII.
[30] *MH v the United Kingdom*, no.11577/06, 22 October 2013, at 77; *Molotchko v Ukraine*, no.12275/10, 26 April 2012.
[31] *X v Finland*, no.34806/04, ECHR 2012, at 170; *Raudevs v Latvia*, no.24086/03, 17 December 2013.

It is also important from an Article 5 ECHR perspective that the court or tribunal in question has the power to order a person's release if it finds that the detention is unlawful; a mere power of recommendation for lifting a measure is insufficient[32]. The CSDL gives the Tribunal the power to make an order amending or revoking an authorization (Article 55(6)(a)), which would in effect result in the lifting of restrictions. The Royal Court, on appeal, may also, inter alia, give any direction which the Tribunal has the power to give (Article 58(3)(c) CSDL).

The role of the Tribunal in reviewing SROLs under Article 55 CSDL was assessed to be compatible with Article 5 ECHR in the original compatibility assessment. Article 59 of the draft Law would insert provisions into Article 55 CSDL to address the situation of persons subject to the transitional provisions, discussed in the preceding section of this memorandum. The intention of these provisions is to ensure that a person who is, at the commencement of the draft Law, already subject to a standard authorization but who would become subject to an authorization for recommended restraints, should be able to challenge the authorization of those restraint measures. Where a person is already subject to a standard authorization at the commencement of the draft Law, that authorization may have been issued many months previous. It could be the case then that P had already made an application to the Tribunal to challenge the scope of the existing standard authorization, but would intend to challenge the authorization of the recommended restraints but for the provision in Article 55(2) CSDL limiting P to making only one application to the Tribunal during the period for which an authorization is in effect.

New Article 55(2A) would apply the new provisions in Article 55 CSDL to those persons who are subject to recommended restraints which are taken to have been authorized in a standard authorization from the commencement of the draft Law (per new Article 48(10)(b)). New Article 55(2B) would inter alia permit a request for review of the standard authorization to be made to the Tribunal no more than once during the period for which the standard authorization remains in effect. These provisions would ensure that a person subject to the transitional provisions will, from the commencement of the draft Law, have a right to apply to the Tribunal for a review of the authorization of the recommended restraints, for such period of that authorization that remains before it expires or is renewed under the existing provisions of Part 5 CSDL. These amendments ensure that the review of standard authorizations under Article 55 CSDL remains compatible with Article 5 ECHR with the introduction of the transitional provisions.

[32] *Benjamin and Wilson v the United Kingdom*, no.282121/95, 26 September 2002 at 33-34.

EXPLANATORY NOTE

This Law, if passed, will amend the Mental Health (Jersey) Law 2016 (the "MHL") to alter the terminology or clarify the description of various individuals covered by its provisions, to alter the individuals to whom duties apply, who must be consulted, who must provide certification or evidence, who can make communication restriction requests, who must receive notice of a decision to withhold a patient's postal item and who are given a right to apply for review of a decision to withhold to the Tribunal. Substantive amendments are made –

(a) to Article 22 (treatment authorization) so that the grounds for renewing a treatment authorization mirror the grounds for the original admission of the patient for treatment;

(b) to Article 84 (review of restrictions, and offence where restriction unlawful) is amended to place an obligation on the Tribunal when reviewing a decision to determine whether the grounds justifying the decision to withhold a postal item or restrict communication continue to exist.

The amendments also update words and phrases and make housekeeping amendments in line with current drafting style.

This Law, if passed, will also make amendments to the Capacity and Self-Determination (Jersey) Law 2016 (the "CSDL"). The type of behaviour that constitutes restraint under Article 9 (certain acts of restraint etc. which are not permitted) is widened and provision that is necessary as a consequence of that change is added to the Minister's standard authorization regime in Article 48. A reference in Article 34 (general provisions concerning delegates) to a delegate's resignation triggering the end of delegate's appointment is removed. The definition of "relevant place" for Part 5 of the CSDL is clarified. Substantive changes to the process to assess a lack of capacity in Article 44 (manner of assessment) are made, including providing 2 routes to obtain the medical evidence required for an assessment in relation to significant restrictions on liberty. In addition to these substantive changes, the amendments correct drafting errors and update words and phrases throughout the CDSL.

Article 1 introduces the amendments to the MHL in *Part 1 (Articles 1-49)*.

Article 2 amends Article 1 (interpretation) of the MHL. The term used for individuals approved by the Minister under Article 6 of the MHL is changed from "authorized officer" to "AMHP" (approved mental health professional). The term "approved practitioner" is changed to "approved clinician". "Electronic" and "electronic communication" are ascribed the definitions used in the Electronic Communications (Jersey) Law 2000. The definition of Health Care Law is introduced. The definition of "postal packet" is moved from Article 83 into this Article and changed to "postal item", the cross-reference to a definition in a UK statute is replaced and it is clarified that the contents of the postal item are included. The defined term "responsible medical officer" is deleted and the new term "responsible clinician" is introduced. *Article 2(2)* inserts a new Article 1A into the MHL setting out the individuals who can be a "responsible clinician", including when the responsible clinician is unable to perform their functions. Article 1A(3) is a transitional provision to ensure that individuals authorised to act as a "responsible medical officer" before this Law comes into force will automatically be taken to be authorised to act as "responsible clinicians" on commencement of this Law.

Article 3 amends Article 4 (appointment of administrator) to make a drafting correction.

Article 4 substitutes Article 6 (authorized officers) of the MHL. The concept of an authorized officer is replaced by the new concept of an "AMHP" and drafting style changes are also made.

Article 5 amend Article 5 (Part 2 heading amended) to make a drafting correction.

Article 6 amends the wording of Article 8 (definition of 'nearest relative') of the MHL so that paragraph (2) provides that if a patient (when they are not admitted to an approved establishment) ordinarily resides with or is cared for by a relative, that relative is the patient's nearest relative. In addition, an incorrect cross-reference is corrected and the heading is shortened.

Article 7 amends the heading of Article 9 ('nearest relative' of certain patients aged under 18) to update drafting style.

Article 8 amends paragraphs (1) and (3) of Article 10 (nomination of nearest person) to improve structure and clarify the meaning of the words "or in writing, substantially to the same effect" that follow "in the prescribed form": the nomination and consent forms are prescribed in the Mental Health (Miscellaneous Provisions and Prescribed Forms) (Jersey) Order 2018).

Article 9 amends Article 13 (rights of nearest person to receive information as to patient's care or treatment) so that all references to "responsible medical officer" are changed to "responsible clinician". It also amends Article 13(1)(a), (2) and (4) so that the duties to notify or inform the nearest person that are set out in those paragraphs are now shared between the responsible clinician and the managers of the approved establishment, if applicable.

Article 10 inserts an interpretation provision at the start of Part 2 in accordance with modern drafting standards and *Article 13* amends Article 20 (effect of admission application) to remove a now redundant definition of "M".

Article 11 amends Article 15 (emergency admissions) to allow either an approved clinician or a registered medical practitioner who has a minimum of 3 years' post-foundation training experience to authorise emergency admissions. Drafting style changes are also made.

Article 12 amends Article 16 (approved practitioners) so that all references to "approved practitioners" are changed to "approved clinician". Persons registered in respect of a registrable occupation under the Health Care (Registration) (Jersey) Law 1995 are added to the list of individuals whom the Minister may approve under Article 16. Paragraph (3) is a new provision that ensures that the Minister's approval before this Law comes into force of a registered medical practitioner as a "approved practitioner" is treated as an approval as an "approved clinician". Drafting style changes are also made.

Article 14 substantively amends Article 22 (treatment authorization) so that the grounds for renewing a treatment authorization in paragraph (4) mirror the grounds for the original admission of the patient for treatment, i.e. the patient must appear to be suffering from mental disorder of a nature or degree that warrants the detention of the patient in an approved establishment for treatment in both instances. The Article also changes all references to "responsible medical officer" to "responsible clinician" and makes drafting style changes to paragraphs (1) and (4).

Article 15 amends Article 39 (treatment not requiring consent) by removing "patient's responsible medical officer" and substituting "approved clinician in charge of the patient's treatment".

Article 16 amends Article 40 (treatment requiring both consent and a second opinion) by altering the categories of professionals with whom the SOAD (second opinion approved doctor, as defined in Article 38(3) of the MHL) must consult before giving a written certificate for certain types of treatment. The SOAD must consult the approved clinician in charge of the treatment that is to be given to the patient and 1 other person who must be a mental health professional who is or has been professionally concerned with the treatment of the patient.

Article 17 makes changes to Article 41 (treatment requiring either consent or a second opinion) so that all references to "responsible medical officer" are changed to "responsible clinician". It amends the list of individuals who must certify in writing that a patient is capable of understanding the nature, purpose and likely effects of the proposed treatment and has consented to receive it. The individuals are now the approved clinician in charge of the treatment that is to be given to the patient, an approved clinician who is a registered medical practitioner or a SOAD. The Article also amends the categories of professionals with whom the SOAD must consult before giving

their certificate in writing, so that that they mirror Article 40 (see *Article 17* above) Drafting structural changes are also made to aid readability.

Article 18 amends Article 44 (emergency treatment) replace "responsible medical officer" with "approved clinician in charge of the treatment".

Article 19 amends Article 47 (establishment of Panel and appointment of qualified persons) so that qualified persons must be medically qualified by virtue of being a registered medical practitioner who is an approved clinician or a practitioner of equivalent experience and qualification registered in a jurisdiction other than Jersey.

Article 20 amends Article 50 (principal functions of the Tribunal) and *Article 21* inserts a new *Article 50A (application to Tribunal for review and discharge).* Article 50 is simplified and Article 50A now contains the right to apply to the Tribunal for a review, more detail of which is set out in the table in Part 2 of the Schedule.

Article 22 makes drafting changes to Article 51 (reference to Tribunal by Minister or Attorney General) to enhance clarity. An additional category of patient in respect of which the Minister or Attorney General may refer a case to the Tribunal is also added: patients liable to be detained under Article 65 if no restriction order has been made under Article 68.

Article 23 introduces the definition of "mental condition report" to increase clarity in Part 9 (criminal justice: powers of court in relation to accused persons suffering mental disorder). *Article 24* makes amendments to Article 61 (remand on bail for report) to use the new "mental condition report" definition and make some drafting style changes.

Article 25 makes amendments to Article 62 (remand to approved establishment for report) to make use of the new definitions of "mental condition report" and "approved clinician" and improve drafting style. Article 62(2)(b) is amended so that the written or oral evidence that admission arrangements have been made must be from a person representing the managers of the approved establishment in question. An error in Article 62(5) is corrected by changing "medical practitioner" to read "registered medical practitioner".

Article 26 and Article 27 amend Article 63 (remand to approved establishment for treatment) and Article 64 (interim orders) to introduce the new terms of "approved clinician" and "responsible clinician". They also amend paragraph (2)(b) in each Article so that written or oral evidence that certain arrangements have been made for admission must come from a person representing the managers of the approved establishment in question. Articles 63(3), 64(4) and 64(5) are also amended so that the written or oral evidence required by those provisions must be the evidence of the responsible clinician.

Articles 28, 29 and 30 add the word "registered" to references to "medical practitioners" in Articles 65 (treatment orders), 66 (guardianship orders) and 67 (directions where sentence of imprisonment to be served in approved establishment). "Registered medical practitioner" is an existing defined term in Article 1 (interpretation) of the MHL. Amendments introducing the new term of "approved clinician" and "responsible clinician" are made. Amendments are made so that written or oral evidence required by Article 65(1)(c) and 66(1)(b) must be the evidence of a person representing the managers of the approved establishment in question.

Article 31 amends Article 69 (transfer and detention orders) to replace "approved practitioner" with "approved clinician", and "responsible medical officer" with "responsible clinician". Article 69(2)(c) is also amended so that the written or oral evidence that admission arrangements have been made must be evidence from a person representing the managers of the approved establishment.

Articles 32 to37, 41 to 42 and 45 update the offence provisions of the MHL listed below in line with modern drafting style:

- Article 73 (offence of wilful neglect)
- Article 74 (sexual offences: prohibited acts)

- Article 75 (sexual offences: relationship of care)
- Article 76 (sexual offences: coercion)
- Article 77 (sexual offences: penalties)
- Article 80 (forgery and false statement)
- Article 91 (offences related to absconding patient)
- Article 92 (offence of obstruction)
- Schedule, Part 1, paragraph 6 (offence of disclosure of information).

Article 38 amends Article 82 (restrictions on access to electronic media and communications etc.) by making some drafting improvements and adding the responsible clinician as a second person to whom a request for a restriction can be made. Amendments also remove the obligation on the managers to give notice of a restriction to a specified person, when a restriction relates to contact with that person.

Article 39 amends Article 83 (restrictions on postal correspondence) of the MHL to delete the definition of "postal packet" and make use of the new defined term "postal item" in Article 1 (interpretation). It also updates the new term of "responsible clinician" and alters the list of people who must be notified (and therefore are given a right to review) of a decision to withhold a postal item. They are the patient, the person who sent the postal item to the patient (if they can be identified), and, if the withheld postal item was sent by the patient, the addressee of the postal item.

Article 40 substitutes Article 84 (review of restrictions, and offence where restriction unlawful). A right to apply for a review to the Mental Health Review Tribunal is given to all those who receive notice of a decision under Article 82 or Article 83. An obligation is placed on the Tribunal when reviewing a decision to determine whether the grounds justifying the decision to withhold a postal item or restrict communication continue to exist. The Tribunal's powers to uphold or lift those decisions to restrict or withhold and issue certain directions to the managers of the approved establishment are also set out. This Article also makes some drafting improvements and updates the offence provision in Article 84 to modern styles.

Article 43 deletes Article 97 (saving), which is now spent.

Article 44 amends the heading to the Schedule to reflect the new Article 50A.

Article 46 substitutes Part 2 (applications to the Tribunal) of the Schedule. Drafting is improved and the structure of the table is altered so that the column "person who may make application" contains an exhaustive list of applicants for each type of decision or exercise of power. A new row for decisions by managers of an approved establishment or responsible medical officers to restrict electronic media, electronic communications or a telephone is introduced and provides for the applicants and time periods for an application to the Tribunal. The last row of the table is deleted because it is not appropriate to include it here. Amendments to the text that accompanies the table make clear than only 1 application can be made within the time limits in the third column of the table unless a previous application made within that time limit has been withdrawn.

Article 47 changes all remaining references to "approved practitioner" to "approved clinician" and "responsible medical officer" to "responsible clinician".

Article 48 changes all remaining references in the MHL to "authorized officer" to "AMHP".

Article 49 makes amendments that are consequential to Article 20 of this Law to change references to "the rights conferred on a patient by Article 50(1)" to "the right to make an application to the Tribunal under Article 50A".

Article 50 introduces *Schedule 1* that contains amendments consequential to *Part 1.*

Article 51 introduces the amendments to the CSDL in *Part 2 (Articles 51 to 62)*.

Article 52 amends Article 9 (certain acts of restraint etc. which are not permitted) so that a person restrains another if their actions are those described under Article 9(2)(a) *or* Article 9(2)(b) of the CSDL, rather than both.

Article 53 amends Article 34 (qualifications of and general provisions concerning delegates) by removing the words "the resignation of the delegate" from the list of events that lead to a delegate's appointment coming to an end.

Article 54 substitutes an altered definition of "relevant place" into Article 37(3) (interpretation and application of Part 5) of the CSDL.

Articles 55 and 56 amend Article 38 (circumstances permitting significant restriction on liberty) and Article 41 (arrangements to be made by Minister: requirement for authorization) of the CSDL so that all references are to a "restriction on liberty" instead of "deprivation of liberty". Some drafting style changes are also made to Article 38(1).

Article 57 amends Article 44 (manner of assessment) of the CSDL. Article 44(2) of the CSDL specifies the way an assessor must carry out their assessment. A new Article 44(2A) of the CSDL provides for 2 routes to obtain the medical evidence required for the assessment. The first is by consulting the responsible medical practitioner who has assessed the patient immediately before the initial interview with the patient. The second route is by means of a written copy of the opinion of a registered medical practitioner who assessed the patient in the 12-month period immediately before the assessor's first interview with the patient. New Article 44(2B) of the CSDL provides that reliance on this second route is permitted only if the assessor is satisfied that the findings continue to be accurate. Amendments to Article 44(3) of the CSDL provide that the registered medical practitioner referred to in Article 44 of the CSDL is the one responsible for the patient's care and treatment *at the time* they made the examination.

Article 58 substitutes Article 48 (standard authorizations). Additional provisions are inserted at the end of Article 48 to deal with the effect of the amendment to Article 9 of the CSDL made by *Article 52* of this Law (the "Article 9 amendment"). Paragraphs (9) and (10) work together to provide for restraint recommendations that have been included in assessor's reports that have in turn resulted in the Minister making standard authorizations. If the effect of the Article 9 amendment is that the restraint now falls into the definition of a "significant restriction of liberty" under the CSDL, the standard authorization is taken, from the commencement of this Law onwards, to authorize those recommended restraints without the need for a fresh standard authorization to be issued by the Minister.

Article 59 amends Article 55 (review of authorizations by tribunal) to allow for 1 application for a review of those restraint recommendations during the period for which the standard authorization remains in effect, irrespective if a review has already been requested under Article 55(1).

Article 60 corrects an error in Article 59 of the CSDL, changing "and" to "or".

Article 61 corrects an incorrect reference to "*curatelles*" to "curatorship".

Article 62 introduces *Schedule 2* that contains amendments consequential to *Part 2*.

Article 63 gives the title by which this Law may be cited and provides that this Law comes into force on a day to specified by the Minister for Health and Social Services by Order.

Schedule 1 contains amendments to 8 other enactments that are either consequential amendments that were overlooked when the MHL commenced, or amendments consequential upon the amendments contained in *Part 1* of this Law.

Schedule 2 contains amendments to 3 enactments that are consequential amendments that were overlooked when the CSDL commenced.

DRAFT MENTAL HEALTH, CAPACITY AND SELF-DETERMINATION (JERSEY) AMENDMENT LAW 202-

Contents

Article

Jersey

DRAFT MENTAL HEALTH, CAPACITY AND SELF-DETERMINATION (JERSEY) AMENDMENT LAW 202-

A LAW to amend the Mental Health (Jersey) Law 2016 and the Capacity and Self-Determination (Jersey) Law 2016.

Adopted by the States	*[date to be inserted]*
Sanctioned by Order of His Majesty in Council	*[date to be inserted]*
Registered by the Royal Court	*[date to be inserted]*
Coming into force	*[date to be inserted]*

THE STATES, subject to the sanction of His Most Excellent Majesty in Council, have adopted the following Law –

PART 1

MENTAL HEALTH (JERSEY) LAW 2016 AMENDED

1 Mental Health (Jersey) Law 2016 amended

Articles 2 to 49 amend the Mental Health (Jersey) Law 2016.

2 Article 1 (interpretation) amended

(1) In Article 1(1) –

(a) after the definition "admission application" there is inserted –

"AMHP" refers to an approved mental health professional within the meaning of Article 6;

"approved clinician" means a person approved by the Minister under Article 16;

(b) the definition "approved practitioner" is deleted;

(c) the definition "authorized officer" is deleted;

(d) after the definition "Court" there is inserted –

"electronic" and "electronic communication" have the meaning given in the Electronic Communications (Jersey) Law 2000;

(e) after the definition "function" there is inserted –

"Health Care Law" means the Health Care (Registration) (Jersey) Law 1995;

(f) after the definition "patient" there is inserted –

"postal item" means a letter, parcel, packet or other article transmissible by post and includes the contents;

(g) for the definition "responsible medical officer" there is substituted –

"responsible clinician" has the meaning given in Article 1A;

(2) After Article 1 there is inserted –

1A Responsible clinician

(1) In this Law, "responsible clinician" means –

(a) the approved clinician with overall responsibility for the following cases –

(i) a patient liable to be detained under Part 3;

(ii) a defendant remanded under Article 62;

(iii) a defendant remanded under Article 63;

(iv) a defendant admitted and detained under Article 64;

(v) a defendant admitted and detained under Article 65;

(vi) a defendant whose sentence of imprisonment has additional directions under Article 67;

(vii) a person who is transferred from prison or secure accommodation and detained under Article 69;

(b) in relation to a patient subject to guardianship under this Law, an approved clinician authorised by the Minister to act, either generally or in a particular case, as the responsible clinician.

(2) But if the person described in paragraph (1)(a) or (b) is unable to perform their functions as responsible clinician, an approved clinician may exercise those functions whilst that person is unable to perform them.

(3) If, before the commencement of the Mental Health, Capacity and Self-Determination (Jersey) Amendment Law 202-, the Minister authorises a registered medical practitioner to act as a responsible medical officer in relation to a patient subject to guardianship under this Law, that authorisation is treated as an authorisation of the responsible medical officer as a responsible clinician.

3 Article 4 (appointment of administrator) amended

In Article 4(2), for "Mental Health Review Tribunal" there is substituted "Tribunal".

4 Article 6 (authorized officers) substituted

For Article 6 there is substituted –

6 Approved mental health professionals

(1) The Minister may approve a person to carry out functions under this Law, including, if appropriate, functions conferred on the Minister under this Law.

(2) That person is referred to as an approved mental health professional (an "AMHP").

(3) The Minister must not approve a person as an AMHP unless –

(a) they are registered in respect of a registrable occupation under the Health Care Law; and

(b) the Minister is satisfied, on the production of evidence that may be prescribed, that the person is experienced and trained in the field of mental health practice and in the operation of legislation relating to mental health.

(4) The Minister may approve a person as an AMHP subject to the terms and conditions that the Minister thinks fit.

(5) An AMHP must perform their functions –

(a) with fairness and impartiality; and

(b) in the best interests of each patient in whose care or treatment they are involved.

(6) The Minister may revoke an approval under this Article, and may vary the terms and conditions upon which an approval is granted.

5 Part 2 heading amended

For the heading to Part 2 there is substituted –

NEAREST PERSON

6 Article 8 (definition of 'nearest relative') amended

In Article 8 –

(a) for the heading there is substituted "Nearest relative";

(b) in paragraph (2), for "for treatment" there is substituted "to an approved establishment";

(c) in paragraph (5)(a), for "paragraph (1)(b) to (h)" there is substituted "paragraph (3)(b) to (h)".

7 Article 9 ('nearest relative' of certain patients aged under 18) amended

In Article 9, for the heading there is substituted "Nearest relative of certain patients aged under 18".

8 Article 10 (nomination of nearest person) amended

(1) For Article 10(1) there is substituted –

(1) A patient who is aged 18 or over may nominate a person as their nearest person –

(a) in the prescribed form; or

(b) in writing by giving substantially the same information as is required to be given in the prescribed form.

(1A) The nomination form must be provided to the person nominated, and a copy of it provided to the Minister.

(2) For Article 10(3) there is substituted –

(3) A nomination under paragraph (1) or (2) cannot take effect unless the person nominated ("R") has given their consent to acting as the patient's nominated nearest person.

(3A) R's consent must be –

(a) in the prescribed form; or

(b) in writing by giving substantially the same information as is required to be given in the prescribed form.

(3B) A nomination under paragraph (1) or (2) may be revoked or varied by further written notice given by the patient or the Minister.

9 Article 13 (rights of nearest person to receive information as to patient's case or treatment) amended

In Article 13 –

(a) in paragraphs (1)(a), (2) and (4), for "responsible medical officer" there is substituted "responsible clinician or managers of the approved establishment, if applicable,";

(b) in paragraphs (1)(b) and (c), and (3)(b) and (c), for "responsible medical officer" there is substituted "responsible clinician".

10 Article 13A (interpretation) inserted

Before Article 14 there is inserted –

13A Interpretation

In this Part, "M" means the managers of the approved establishment.

11 Article 15 (emergency admissions) amended

For Article 15 there is substituted –

15 Emergency admissions

(1) This Article applies if a patient –

(a) is brought to, or presents themselves at, an approved establishment; or

(b) has been admitted to an approved establishment under the arrangements mentioned in Article 14(1)(a), but no longer consents to remain.

(2) A registered medical practitioner who has a minimum of 3 years' post-foundation training experience or an approved clinician may authorize the immediate admission of the patient, if they are of the opinion that there is an

urgent necessity for the patient to be admitted for assessment on the grounds that –

(a) it is likely that the patient is suffering from mental disorder; and

(b) allowing the patient to remain at liberty would endanger either the patient's safety or that of other people.

(3) The registered medical practitioner or approved clinician must record their authorization under paragraph (2) in writing and send a copy as soon as practicable to the Minister.

(4) A patient admitted under paragraph (2) may be detained for a period that expires on whichever of the following occurs first –

(a) the end of the period of 72 hours beginning with the time when the opinion mentioned in paragraph (2) is formed;

(b) an approved clinician forms the opinion that the grounds in paragraph (2) no longer apply in respect of the patient;

(c) the patient is admitted for assessment or treatment under Article 21 or 22.

(5) For the purposes of paragraph (2), there is no urgent necessity if an application for assessment or treatment authorization under Article 21 or 22 could be made without undue delay.

(6) The approved clinician must record their opinion under paragraph (4)(b) in writing and send a copy as soon as practicable to the Minister.

12 Article 16 (approved practitioners) substituted

For Article 16 there is substituted –

16 Approved clinicians

(1) The Minister may approve the following individuals as an approved clinician if the Minister is satisfied, on the production of evidence that may be prescribed, that the individual has sufficient experience and training in the field of mental health and in the operation of legislation relating to mental health –

(a) a registered medical practitioner;

(b) a person registered in respect of a registrable occupation under the Health Care Law.

(2) The Minister may –

(a) approve an individual on the terms and conditions that the Minister thinks fit;

(b) revoke the approval; and

(c) vary the terms and conditions of the approval.

(3) The Minister's approval of a registered medical practitioner as an approved practitioner before the commencement of the Mental Health, Capacity and Self-Determination (Jersey) Amendment Law 202- is treated as an approval of the registered medical practitioner as an approved clinician.

13 Article 20 (effect of admission application) amended

In Article 20(1)(b), for "the managers of the approved establishment ("M" in this Part)" there is substituted "M".

14 Article 22 (treatment authorization) amended

In Article 22 –

(a) for paragraph (1)(b) there is substituted –

> (b) it is necessary that the patient is detained in an approved establishment for treatment –
>
> > (i) in the interests of the patient's health or safety; or
> >
> > (ii) for the protection of other persons.

(b) in the introductory words of paragraph (4) and paragraph (6), for "responsible medical officer" there is substituted "responsible clinician";

(c) for paragraph (4)(a) there is substituted –

> (a) the renewal of the treatment authorization, if it appears to the responsible clinician that –
>
> > (i) the patient continues to be suffering from mental disorder of a nature or degree that warrants the detention of the patient in an approved establishment for treatment; and
> >
> > (ii) it is necessary that the patient continues to be liable to be detained in an approved establishment for treatment –
> >
> > > (A) in the interests of the patient's health or safety; or
> > >
> > > (B) for the protection of other persons; or

15 Article 39 (treatment not requiring consent) amended

In Article 39(b), for "patient's responsible medical officer" there is substituted "approved clinician in charge of the patient's treatment".

16 Article 40 (treatment requiring both consent and a second opinion) amended

(1) In Article 40(3)(a), for "patient's responsible medical officer" there is substituted "approved clinician in charge of the treatment that is to be given to the patient".

(2) For Article 40(3)(b) there is substituted –

> (b) 1 other person who must be a mental health professional who is or has been professionally concerned with the treatment of the patient,

17 Article 41 (treatment requiring either consent or a second opinion) amended

In Article 41 –

(a) for paragraph (1)(a) there is substituted –

> (a) the patient has consented to the treatment, and the following has certified in writing that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment and has consented to receive it –

(i) the approved clinician in charge of the treatment that is to be given to the patient;

(ii) an approved clinician who is a registered medical practitioner; or

(iii) a SOAD; or

(b) for paragraph (4) there is substituted –

(4) A SOAD must not give a certificate in writing as required by paragraph (1)(b) unless, in accordance with any further provision made by a code of practice on consultation, the SOAD has consulted –

(a) the approved clinician in charge of the treatment to be given to the patient; and

(b) 1 other person who must be a mental health professional who is or has been professionally concerned with the treatment of the patient.

18 Article 44 (emergency treatment) amended

In Article 44(2), for "responsible medical officer" there is substituted "approved clinician in charge of the treatment".

19 Article 47 (establishment of Panel and appointment of qualified persons) amended

In Article 47(3)(b), for "approved practitioner" there is substituted "registered medical practitioner who is an approved clinician".

20 Article 50 (principal functions of the Tribunal) amended

For the text of Article 50 there is substituted –

(1) The principal functions of the Tribunal are to –

(a) determine applications made under Part 2 of the Schedule;

(b) determine references made by the Minister or the Attorney General under Article 51; and

(c) review authorizations for removal under Article 85.

(2) The Tribunal must also discharge other functions that are conferred on it under this Law or under another enactment.

21 Article 50A (application to Tribunal for review or discharge) inserted

After Article 50 there is inserted –

50A Application to Tribunal for review or discharge

(1) An applicant may apply to the Tribunal, in the form and manner prescribed, for –

(a) a review of a decision or exercise of a power; and

(b) the discharge of a patient if the patient is liable to be detained for the time being.

(2) Part 2 of the Schedule makes further provision about an application under this Article.

(3) In this Article, "applicant" means a person listed in the table in the Schedule, Part 2, paragraph 7.

22 Article 51 (reference to Tribunal by Minister or Attorney General) amended

For the text of Article 51 there is substituted –

(1) The Minister or the Attorney General may, if they think fit, refer the case of any of the following to the Tribunal –

(a) a patient liable to be detained under Part 3;

(b) a patient subject to guardianship under Part 4; or

(c) a patient liable to be detained under Article 65 if no restriction order has been made under Article 68.

(2) The Tribunal must deal with a reference under paragraph (1) as if it were an application made by the patient under Article 50A.

23 Article 60 (interpretation and application of Part 9) amended

In Article 60(1)(c), before the definition "place of safety" there is inserted –

"mental condition report" means a report on the defendant's mental condition;

24 Article 61 (remand on bail for report) amended

For Article 61(1) there is substituted –

(1) A court may remand the defendant on bail for the purpose of obtaining a mental condition report and in doing so may order that the person attend an approved establishment, at times and on conditions that the court may specify, to enable the preparation of the report.

25 Article 62 (remand to approved establishment for report) amended

(1) For Article 62(1) there is substituted –

(1) The court may remand a defendant to a specified approved establishment for the purpose of obtaining a mental condition report if –

(a) it is satisfied of the matters specified in paragraph (2); and

(b) it is of the opinion that –

(i) the defendant would not comply with an order under Article 61; or

(ii) were the defendant remanded on bail under that Article, it would otherwise be impracticable for a mental condition report to be prepared.

(2) In Article 62(2) –

(a) in sub-paragraph (a), for "approved practitioner" there is substituted "approved clinician";

(b) in sub-paragraph (b), for "the approved practitioner who would be responsible for making the report, or some other" there is substituted "a".

(3) In Article 62(3) –

(a) for "approved practitioner" there is inserted "approved clinician";

(b) after "making the" there is inserted "mental condition";

(c) for "the assessment of the defendant's medical condition" there is substituted "that report".

(4) In Article 62(5)(a), before "medical practitioner" there is inserted "registered".

26 Article 63 (remand to approved establishment for treatment) amended

(1) In Article 63(2) –

(a) in sub-paragraph (a), for "approved practitioner" there is substituted "approved clinician";

(b) in sub-paragraph (b), for "the responsible medical officer, or some other" there is substituted "a".

(2) In Article 63(3), for "approved practitioner responsible for making the report" there is substituted "responsible clinician".

27 Article 64 (interim orders) amended

(1) In Article 64(2) –

(a) in sub-paragraph (a), for "approved practitioner" there is substituted "approved clinician";

(b) in sub-paragraph (b), for "the responsible medical officer, or some other" there is substituted "a".

(2) In Article 64(4) and (5)(b), for "responsible medical officer" there is substituted "responsible clinician".

28 Article 65 (treatment orders) amended

(1) In Article 65(1)(a) –

(a) after "2" there is inserted "registered";

(b) for "approved practitioner" there is substituted "approved clinician".

(2) In Article 65(1)(c), for "the approved practitioner or some other" there is substituted "a".

29 Article 66 (guardianship orders) amended

In Article 66(1)(a) –

(a) after "2" there is inserted "registered";

(b) for "approved practitioner" there is substituted "approved clinician".

30 Article 67 (directions where sentence of imprisonment to be served in approved establishment) amended

(1) In Article 67(1)(a) –

(a) after "2" there is inserted "registered";

(b) for "approved practitioner" there is substituted "approved clinician".

(2) In Article 67(1)(b), for "the responsible medical officer or some other" there is substituted "a".

(3) In Article 67(7)(b), for "responsible medical officer" there is substituted "responsible clinician".

31 Article 69 (transfer and detention orders) amended

(1) In Article 69(2)(a), for "approved practitioner" there is substituted "approved clinician".

(2) In Article 69(2)(c), for "the approved practitioner responsible for giving the evidence under sub-paragraph (a), or another" there is substituted "a".

(3) In Article 69(7) and (11), for "responsible medical officer" there is substituted "responsible clinician".

32 Article 73 (offence of wilful neglect) amended

(1) In Article 73(1), for the introductory words there is substituted "A manager or member of staff of an approved establishment commits an offence if they ill-treat or wilfully neglect".

(2) In Article 73(2), for the introductory words there is substituted "An individual commits an offence if the individual ill-treats or wilfully neglects".

(3) For Article 73(3) there is substituted –

(3) A person who commits an offence under this Article is liable to imprisonment for a term of 5 years and to a fine.

33 Article 74 (sexual offences: prohibited acts) amended

In Article 74(1), for "It is an offence for any person ("A") to commit" there is substituted "A person ("A") commits an offence if A commits".

34 Article 75 (sexual offences: relationship of care) amended

For Article 75(1) there is substituted –

(1) A person ("A") involved in the care of a person ("B") who is suffering from a mental disorder in a way described in paragraph (3) or (4) commits an offence if A –

(a) commits a prohibited act with, towards or in relation to B; or

(b) procures by inducement, threat or deception B's participation in a prohibited act.

35 Article 76 (sexual offences: coercion) amended

In Article 76, for "It is an offence for any person ("A") to procure" there is substituted "A person ("A") commits an offence if A procures".

36 Article 77 (sexual offences: penalties) amended

In Article 77(1) and (2) for "guilty of" there is substituted "who commits".

37 Article 80 (forgery and false statements) substituted

For Article 80 there is substituted –

80 Offences: forgery and false statements

(1) A person commits an offence if the person, with intent to deceive –

(a) forges a document required or authorised to be made under or for the purposes of this Law; or

(b) uses, allows another person to use, or makes or has in their possession a document that the person knows to be forged or to so closely resemble a document listed in paragraph (2) as to be calculated to deceive.

(2) The documents mentioned in paragraph (1)(b) include –

(a) an application under Part 3;

(b) a medical recommendation, report or information required to be made, given or provided under this Law; or

(c) another document required or authorised to be made under or for a purpose of this Law.

(3) A person commits an offence if the person –

(a) knowingly makes a false entry or statement in a document listed in paragraph (2); or

(b) with intent to deceive, makes use of that false entry or statement knowing it to be false.

(4) A person who commits an offence under this Article is liable to imprisonment for a term of 2 years and to a fine.

38 Article 82 (restrictions on access to electronic media and communications etc.) amended

(1) For Article 82(1) there is substituted –

(1) The managers of an approved establishment may restrict the access of a patient detained in that establishment to the following means of communication ("restriction on communication") –

(a) electronic media or electronic communications;

(b) a telephone (including any form of personal mobile device).

(1A) A restriction on communication must not be imposed unless, in the opinion of the managers, it is necessary to do so on the following grounds –

(a) that it is in the interests of the health or safety of the patient; or

(b) that it is for the protection of other persons.

(2) For Article 82(2) there is substituted –

"(2) A restriction on communication may, in particular, include –

(a) restriction of the ability of a patient to contact a specified person by any means mentioned in paragraph (1), if the person has requested that restriction by notice in writing to the managers or to the responsible clinician; and

(b) confiscation of an article or device that may be used for the purposes of accessing electronic media or electronic communications.

(3) For Article 82(3) there is substituted –

"(3) If a restriction on communication is imposed –

(a) the managers must, no later than 7 days after it is imposed, notify the patient in writing of the restriction and of the right to review under Article 84; and

(b) the managers must record in writing the fact and nature of the restriction.

(4) In Article 82(4) –

(a) for "Paragraph (1) shall not apply so as to" there is substituted "A restriction imposed under paragraph (1) does not";

(b) in sub-paragraph (i), for "Mental Health Review Tribunal" there is substituted "Tribunal".

39 Article 83 (restrictions on postal correspondence) amended

(1) For Article 83(1) there is substituted –

"(1) The managers of an approved establishment may withhold a postal item addressed to a patient detained in that establishment.

(1A) A decision to withhold under paragraph (1) must not be imposed unless, in the opinion of the managers, it is necessary to do so on the following grounds –

(a) in the interests of the health or safety of the patient; or

(b) for the protection of other persons.

(2) For Article 83(2) there is substituted –

"(2) The managers of an approved establishment may withhold a postal item addressed by a patient detained in that establishment from dispatch on the following grounds –

(a) that the addressee has given notice in writing to the managers or the responsible clinician that any communications addressed to the addressee by the patient should be withheld; or

(b) that it appears to the managers that the communication –

(i) would be likely to cause distress to the addressee; or

(ii) might cause danger to any person.

(3) In Article 83(3) –

(a) for "Paragraphs (1) and (2) shall not apply so as to" there is substituted "Restrictions imposed under this Article must not";

(b) in sub-paragraph (i), for "Mental Health Review Tribunal" there is substituted "Tribunal".

(4) In Article 83(4) –

(a) for "packet" there is substituted "item";

(b) for "(1)" there is substituted "(1A)".

(5) For Article 83(5) there is substituted –

(5) If a postal item is withheld under this Article –

(a) the managers must, no later than 7 days after the postal item is withheld, give notice in writing of the fact and of the right to review under Article 84 –

(i) to the patient;

(ii) if paragraph (1) applies, to the person who sent the postal item (if that person can be identified from the item or its contents); and

(iii) if paragraph (2) applies, to the addressee; and

(b) the managers must record in writing the fact of, and reason for, the withholding.

(6) Article 83(6) is deleted.

40 Article 84 (review of restrictions, and offence where restriction unlawful) substituted

For Article 84 there is substituted –

84 Review of restrictions, and offence if restriction unlawful

(1) A person given notice under Article 82(3)(a) or Article 83(5)(a) may apply to the Tribunal, in the prescribed form and manner, for a review of a decision under Article 82 (restrictions on access to electronic media and communications etc.) or Article 83 (restrictions on postal correspondence).

(2) An application for review must be made within the period of 6 months beginning with the date of receipt of the notice.

(3) On an application for review, the Tribunal must determine whether the grounds specified in Article 82(1A), 83(1A) or 83(2) continue to exist in respect of the decision –

(a) to impose a restriction on communication under Article 82(1); or

(b) to withhold a postal item under Article 83(1) or (2).

(4) If the Tribunal determines that the grounds no longer exist, it must order the managers of the approved establishment –

(a) to lift the restriction on communication; or

(b) to release the postal item to the patient or dispatch it.

(5) If the Tribunal determines that grounds continue to exist, it must uphold the decision and may direct the managers of the approved establishment –

(a) in a case falling under Article 82(1), to modify the restriction on communication in whatever manner the Tribunal directs; or

(b) in a case falling under Article 83, to release some of the contents of the postal item if continuing to withhold that content would not meet the grounds for withholding the postal item under Article 83(1A) or 83(2).

(6) Unless a person imposes the restriction under Article 82 or 83, a person commits an offence if they restrict –

(a) a patient's access to electronic media or to electronic communications or to a telephone (including any form of personal mobile device); or

(b) the receipt or dispatch of a postal item by a patient.

(7) A person who commits an offence under this Article is liable to a fine of level 3 on the standard scale.

41 Article 91 (offence of assisting patient to abscond) substituted

For Article 91 there is substituted –

91 Offences related to absconding patient

(1) A person commits an offence if they induce or knowingly assist –

(a) a patient who is liable to be detained under this Law to absent themselves without leave from an approved establishment; or

(b) a patient who is subject to guardianship under this Law to absent themselves without leave from their guardian's custody.

(2) A person commits an offence if they –

(a) knowingly harbour a patient who is –

(i) absent without leave; or

(ii) otherwise at large and liable to be retaken under Part 5 or Part 9;

(b) give assistance to a patient with intent to prevent, hinder or interfere with them being retaken into custody or returned to an approved establishment.

(3) A person who commits an offence under this Article is liable to imprisonment for a term of 2 years and to a fine.

42 Article 92 (offence of obstruction) substituted

For Article 92 there is substituted –

92 Offences of obstruction

(1) A person commits an offence if they –

(a) refuse to allow the inspection of the whole or part of –

(i) an approved establishment; or

(ii) premises within the definition "place of safety" under Article 34(1);

(b) without reasonable excuse, refuse to allow a visit, interview or examination of a patient by a person authorised to do so under this Law (the "authorised person");

(c) refuse to produce a document or record that the authorised person requires for inspection; or

(d) otherwise obstruct the authorised person in the exercise of their functions under this Law.

(2) A person who commits an offence under this Article is liable to imprisonment for a term of 3 months and to a fine of level 3 on the standard scale.

43 Article 97 (saving) deleted

Article 97 is deleted.

44 Schedule heading amended

In the Schedule heading, for "50" there is substituted "50A".

45 Schedule, Part 1 (constitution and proceedings of mental health review tribunal) amended

In the Schedule, Part 1, for paragraph 6 there is substituted –

6 Offence of disclosure of information

(1) A member of the Panel commits an offence if the member discloses a document or other information –

(a) relating to the business or affairs of a person; and

(b) that is acquired by the member in the course of exercising their functions as a member of the Panel.

(2) But no offence is committed if the disclosure is made –

(a) with the consent of (or with consent lawfully given on behalf of) –

(i) the person to whom the disclosure relates; and

(ii) if different, the person from whom the document or information was acquired; or

(b) to the extent that the disclosure is necessary –

(i) to enable the member to exercise functions as a member of the Panel;

(ii) in the interests of the investigation, detection, prevention or prosecution of crime; or

(iii) to comply with an order of a court.

(3) A person who commits an offence under this Article is liable to a fine.

46 Schedule, Part 2 (applications to the Tribunal) amended

For Part 2 there is substituted –

PART 2

APPLICATIONS TO THE TRIBUNAL

7 Application to Tribunal for review or discharge under Article 50A

Only 1 application may be made in respect of a decision or exercise of power within the time limit specified in the table below, unless a previous application made within the time limit has been withdrawn.

Decision or exercise of power	Person who may make application	Time limit for making application
Detention under an assessment authorisation (including detention during the initial period (as defined in Article 20(1)(b))	(a) the patient to whom the authorisation relates; or (b) the patient's nearest person	14 days beginning with the day on which notice is given under Article 20(2) that the patient is admitted to an approved establishment
First detention under a treatment authorisation (including detention during the initial period (as defined in Article 20(1)(b))	(a) the patient to whom the authorisation relates; or (b) the patient's nearest person	6 months beginning with the day on which notice is given under Article 20(2) that the patient is admitted to an approved establishment
First renewal of detention under a treatment authorisation	(a) the patient to whom the authorisation relates; or (b) the patient's nearest person	6 months beginning with the day on which the authorisation is first renewed
Subsequent renewal of detention under a treatment authorisation	(a) the patient to whom the authorisation relates; or (b) the patient's nearest person	12 months beginning with the day on which the authorisation is renewed
Exercise of power to recall from absence	(a) the patient in respect of whom the power is exercised; or (b) the patient's nearest person	14 days beginning with the day on which the power is exercised
Detention in custody following absence without leave	(a) the patient who is taken into custody; or (b) the patient's nearest person	28 days beginning with the day on which the patient is detained
Reception into guardianship	(a) the patient to whom	6 months beginning with the

Decision or exercise of power	Person who may make application	Time limit for making application
	the guardianship authorisation relates; or (b) the patient's nearest person	day on which the guardianship authorisation is made
The making or renewal of a treatment order	(a) the patient to whom the order relates; or (b) the patient's nearest person	6 months beginning with the day on which the order is made or renewed
Decision by managers of an approved establishment to restrict access to electronic media, electronic communications or a telephone	(a) the patient whose access is restricted; or (b) the patient's nearest person	6 months beginning with the day on which the applicant received notice under Article 82(3) that access is restricted
Decision by managers of an approved establishment to withhold a postal item	(a) the patient whose postal item is withheld; (b) the patient's nearest person; (c) the person (other than the patient) who sent the postal item to the patient; or (d) the addressee of the postal item	6 months beginning with the day on which the applicant receives notice under Article 83(5) that the postal item has been withheld

47 Amendments consequential to Article 2 of this Law

(1) In the following provisions, for "approved practitioner" there is substituted "approved clinician" –

(a) Article 17(1)(b)(iii) and (3);

(b) Article 18(3);

(c) Article 19(2);

(d) Article 28(5);

(e) Article 29(4);

(f) Article 45(1) and (2).

(2) In Article 19(2), for "approved practitioners" there is substituted "approved clinicians".

(3) In the following provisions, for "responsible medical officer" there is substituted "responsible clinician" –

(a) Article 14(1)(b);

(b) Article 24(1), (2)(b), (4), (6) in the 2 places it appears, (7) and (8), and (10) in the 2 places it appears;

(c) Article 27(1), (2) in the 2 places it appears, (4), and (5) in the 3 places it appears;

(d) Article 28(5)(b);

(e) Article 33(4) in the 2 places it appears;

(f) Article 45(2)(b);

(g) Article 68(6).

(4) in the following provisions, for "that officer" there is substituted "the responsible clinician" –

(a) Article 24(6) and (7);

(b) Article 27(5)(a).

48 Amendments consequential to Article 4 of this Law

(1) In the following provisions, for "authorized officer" there is substituted "AMHP" –

(a) Article 11(2)(b) and (3);

(b) Article 18(2)(a) and (c);

(c) Article 19(3)(a);

(d) Article 29(2)(a);

(e) Article 30(2)(c);

(f) Article 31(1)(d);

(g) Article 35(1), (2)(a), (5) and (6)(a);

(h) Article 37(2)(c).

(2) In Article 12(2)(b), for "a duly authorized officer" there is substituted "an AMHP".

(3) In Article 79(5)(c), for "authorized officers" there is substituted "AMHPs".

49 Amendments consequential to Article 20 of this Law

(1) In the following provisions, for "the rights conferred on a patient by Article 50(1)" there is substituted "the right to make an application to the Tribunal under Article 50A" –

(a) Article 20(5);

(b) Article 21(5);

(c) Article 22(9);

(d) Article 24(7);

(e) Article 25(3);

(f) Article 30(3).

(2) In Article 53(1), for "under Article 50 or 51 to apply to the Tribunal" there is substituted "to apply to the Tribunal under Article 50A or refer a patient's case to the Tribunal under Article 51".

50 Consequential amendments

Schedule 1 contains amendments consequential to this Part.

PART 2

CAPACITY AND SELF-DETERMINATION (JERSEY) LAW 2016 AMENDED

51 Capacity and Self-Determination (Jersey) Law 2016 amended

Articles 52 to 61 amend the Capacity and Self-Determination (Jersey) Law 2016.

52 Article 9 (certain acts of restraint etc. which are not permitted) amended

In Article 9(2)(a), for "and" there is substituted "or".

53 Article 34 (qualifications of and general provisions concerning delegates) amended

In Article 34(10), "or upon the delegate's resignation," is deleted.

54 Article 37 (interpretation and application of Part 5) amended

For Article 37(3) there is substituted –

(3) In this Part, a "relevant place" means –

(a) a hospital (except its emergency department);

(b) an approved care home;

(c) premises on which the conditions of a person's registration under the Regulation of Care (Jersey) Law 2014 permit them to carry on a regulated activity; or

(d) an establishment designated by the Minister for the purposes of providing health or social care, or both health and social care.

55 Article 38 (circumstances permitting significant restriction on liberty) amended

For Article 38(1) there is substituted –

(1) The manager ("M") of a relevant place in which P is residing must not impose on P a significant restriction on P's liberty unless 1 of the criteria in paragraph (2) is fulfilled in respect of P.

56 Article 41 (arrangements to be made by Minister: requirement for authorization) amended

In Article 41(1) –

(a) for "deprivation of" there is substituted "restriction on";

(b) in sub-paragraph (b), for "such a deprivation" there is substituted "the restriction".

57 Article 44 (manner of assessment) amended

(1) For Article 44(2) there is substituted –

(2) An assessor must carry out the assessment by –

(a) conducting 1 or more interviews with P; and

(b) obtaining medical evidence that confirms that, at the date of the assessment, P suffers from an impairment or a disturbance in the functioning of their mind or brain.

(2) After Article 44(2) there is inserted –

(2A) The assessor must obtain the medical evidence –

(a) by consulting the registered medical practitioner who has assessed P immediately before the assessor's first interview with P under paragraph (2)(a); or

(b) by means of a written copy of the opinion of a registered medical practitioner who assessed P in the 12-month period immediately before the assessor's first interview with P under paragraph (2)(a) (the "previous opinion").

(2B) The assessor can rely on the previous opinion only if satisfied that, at the time of the assessor's own assessment, the previous opinion continues to be accurate.

(3) In Article 44(3) –

(a) for "paragraph (2)(b)," there is substituted "paragraph (2A)";

(b) in sub-paragraph (a), after "who" there is inserted ", at the time of the assessment,".

58 Article 48 (standard authorizations) amended

For Article 48 there is substituted –

48 Standard authorizations

(1) The Minister may authorize the imposition of significant restrictions on P's liberty (a "standard authorization") if the Minister is satisfied that –

(a) an assessment of P has been duly completed in accordance with Articles 44 and 45; and

(b) the report of the assessment is affirmative.

(2) A standard authorization must not authorize the imposition of significant restrictions on P's liberty for a period of longer than 12 months beginning with the date the standard authorization takes effect.

(3) The Minister must give notice in writing of the standard authorization to the assessor and to M as soon as practicable after the authorization was given.

(4) A standard authorization must specify –

(a) P's name;

(b) M's name and the name of any other registered person concerned;

(c) the date (or if applicable, the event) on which, and the period during which, the authorization is to take effect;

(d) having regard to Article 45(2)(e), the nature and extent of the significant restrictions on P's liberty that are authorized to be imposed; and

(e) any conditions or directions relating to the imposition of those restrictions.

(5) The Minister may make further provision in the code of practice issued under Article 68 about the form and content of a standard authorization.

(6) Despite paragraph (4)(d) the Minister may authorize significant restrictions to be imposed on P's liberty that are different (whether in specific respects or by their nature) to a restriction that has been recommended by the assessor.

(7) If the Minister considers it is in P's best interests to do so, the Minister may authorize a significant restriction that conflicts with a decision of –

(a) a person on whom P has conferred a lasting power of attorney under Part 2; or

(b) a delegate appointed by the Court under Part 4.

(8) Nothing in this Article is to be taken to permit the Minister to authorize a significant restriction on P's liberty that conflicts or would conflict with a valid advance decision made by P under Part 3.

(9) Paragraph (10) applies if an assessor's report under Article 45 made before the commencement of the Amendment Law contained recommendations for the application of restraints ("recommended restraints").

(10) A standard authorization given further to the assessor's report before the commencement of the Amendment Law –

(a) for the avoidance of doubt, is not taken to have authorized recommended restraints; but

(b) from the commencement of the Amendment Law only, the recommended restraints are taken to be authorized by that standard authorization.

(11) In this Article –

"Amendment Law" means the Mental Health, Capacity and Self-Determination Amendment (Jersey) Law 202-;

"restraints" means restraints within the meaning of Article 9(2) as at the date of commencement of the Amendment Law.

(12) This paragraph and paragraphs (9) to (11) expire 12 months after the Amendment Law is registered.

59 Article 55 (review of authorizations by Tribunal) amended

In Article 55 –

(a) after paragraph (2) there is inserted –

(2A) Paragraph (2B) applies if, in accordance with Article 48(10)(b), P is subject to recommended restraints taken to be authorized in a standard authorization from the commencement of the Amendment Law.

(2B) A request for a review of that standard authorization may be made by application to the Tribunal –

(a) by a person listed in paragraph (1)(b); and

(b) no more than once during the period for which that standard authorization remains in effect.

(2C) In paragraph (2A) –

"Amendment Law" has the meaning given in Article 48(11);

"recommended restraints" has the meaning given in Article 48(9);

"restraints" has the meaning given in Article 48(11).

(2D) This paragraph and paragraphs (2A), (2B) and (2C) expire 12 months after the Amendment Law is registered.

(b) in paragraph (3)(a), for "paragraph (1)" there is substituted "this Article";

(c) in paragraph (3)(b), "such" is deleted;

(d) in paragraph (3)(c), for "the application" there is substituted "an application";

(e) in paragraph (4), for "under paragraph (1)" there is substituted "for review under this Article".

60 Article 59 (temporary restriction of liberty for purpose of life-sustaining treatment) amended

In Article 59(2), for "health and safety" there is substituted "health or safety".

61 Article 72 (repeal) amended

In Article 72, for "*curatelles* shall cease" there is substituted "curatorship ceases".

62 Consequential amendments

Schedule 2 contains amendments consequential to this Part.

PART 3

CITATION AND COMMENCEMENT

63 Citation and commencement

This Law may be cited as the Mental Health, Capacity and Self-Determination (Jersey) Amendment Law 202- and comes into force on a day to be specified by the Minister for Health and Social Services by Order.

SCHEDULE 1

(Article 50)

AMENDMENTS CONSEQUENTIAL TO PART 1 OF THIS LAW

1 Capacity and Self-Determination (Independent Capacity Advocates) (Jersey) Regulations 2018

In the Capacity and Self-Determination (Independent Capacity Advocates) (Jersey) Regulations 2018 –

(a) in Regulation 6(5)(a) (cessation of services of ICA), for "responsible medical officer" there is substituted "responsible clinician";

(b) in Regulation 7(2)(c) (termination of appointment of ICA), for "responsible medical officer" there is substituted "responsible clinician".

2 Capacity and Self-Determination (Jersey) Law 2016

In Article 26(2)(b) (application in case of person admitted to approved establishment) of the Capacity and Self-Determination (Jersey) Law 2016, for "responsible medical officer" there is substituted "responsible clinician".

3 Children (Jersey) Law 2002

In Article 72(5)(c)(ii) and (10) (power of court to order scientific tests in cases of disputed parentage) of the Children (Jersey) Law 2002, for "responsible medical officer" there is substituted "responsible clinician".

4 Commissioner for Standards (Jersey) Law 2017

For Article 6(2)(f) (vacancy in office) of the Commissioner for Standards (Jersey) Law 2017 there is substituted –

(f) is detained or subject to guardianship under the Mental Health (Jersey) Law 2016;

5 Mental Health and Capacity (Review Tribunal) (Procedure) (Jersey) Order 2018

In the Mental Health and Capacity (Review Tribunal) (Procedure) (Jersey) Order 2018, for "responsible medical officer" there is substituted "responsible clinician" in –

(a) Article 5(5)(b)(ii) (notification by Tribunal to responsible authority and others);

(b) Article 6(4)(a) (statement to be supplied by responsible authority to Tribunal);

(c) the Schedule (statement by responsible authority), Part B (reports and observations), in the 2 places it appears.

6 Mental Health (Guardianship) (Jersey) Regulations 2018

In the Mental Health (Guardianship) (Jersey) Regulations 2018 –

(a) for "authorized officer" there is substituted "AMHP" in –

(i) Regulation 4(1) (transfer of patient into guardianship from approved establishment);

(ii) Regulation 5(2)(a) and (b) and (4)(b) (transfer of patient into approved establishment from guardianship);

(b) for "approved practitioner" there is substituted "approved clinician" in –

(i) Regulation 4(2)(a) (transfer of patient into guardianship from approved establishment);

(ii) Regulation 4(2)(b);

(iii) Regulation 4(4)(a);

(c) for "responsible medical officer" there is substituted "responsible clinician" in –

(i) Regulation 2(5) (general duties of private guardians);

(ii) Regulation 2(6) in the 2 places it appears;

(iii) Regulation 3(6) (duties arising upon, and arrangements for, transfer of patient between guardians);

(iv) Regulation 3(7)(a);

(v) Regulation 5(2)(a)(ii) (transfer of patient into approved establishment from guardianship).

7 Mental Health (Independent Mental Health Advocates) (Jersey) Regulations 2018

In the Mental Health (Independent Mental Health Advocates) (Jersey) Regulations 2018 –

(a) in Regulation 7(6)(c) (nature of services to be provided by IMHAs), for "approved practitioner" there is substituted "approved clinician";

(b) for "responsible medical officer" there is substituted "responsible clinician" in –

(i) Regulation 7(6)(b) (nature of services to be provided by IMHAs);

(ii) Regulation 8(5) (cessation of services of IMHA);

(iii) Regulation 9(2)(c) (termination of appointment of IMHA).

8 Prison (Independent Prison Monitoring Board) (Jersey) Regulations 2017

In Regulation 4(2)(e) (membership of the monitoring board) of the Prison (Independent Prison Monitoring Board) (Jersey) Regulations 2017, for "under Article 14 of the Mental Health (Jersey) Law 1969" there is substituted "under Article 29 of the Mental Health (Jersey) Law 2016".

SCHEDULE 2

(Article 62)

AMENDMENTS CONSEQUENTIAL TO PART 2 OF THIS LAW

1 Agriculture (Guaranteed Prices and Financial Assistance) (Jersey) Law 1965

In Article 1(1) (interpretation) of the Agriculture (Guaranteed Prices and Financial Assistance) (Jersey) Law 1965, in the definition "owner", for "the curator of a person under interdiction" there is substituted "the delegate of a person appointed under Article 24 of the Capacity and Self-Determination (Jersey) Law 2016".

2 Commissioner for Standards (Jersey) Law 2017

For Article 6(2)(g) (vacancy in office) of the Commissioner for Standards (Jersey) Law 2017 there is substituted –

> (g) has a delegate appointed under the Capacity and Self-Determination (Jersey) Law 2016;

3 Prison (Independent Prison Monitoring Board) (Jersey) Regulations 2017

In Regulation 4(2)(e) (membership of the monitoring board) of the Prison (Independent Prison Monitoring Board) (Jersey) Regulations 2017, for "has a curator appointed under Article 43 of the Mental Health (Jersey) Law 1969 to manage and administer his or her property and affairs" there is substituted "a person who has a delegate appointed under Article 24 of the Capacity and Self-Determination (Jersey) Law 2016 to manage their property and affairs or health or welfare".