STATES OF JERSEY

DRAFT MENTAL HEALTH LEGISLATION (P.42/2018, P.43/2018, P.44/2018, P.45/2018, P.46/2018, P.47/2018, P.48/2018): COMMENTS

Presented to the States on 6th April 2018
by the Health and Social Security Scrutiny Panel

STATES GREFFE

COMMENTS

Introduction

1. The Mental Health (Jersey) Law 2016 (from P.78/2016) ("the Mental Health Law") and the Capacity and Self-Determination (Jersey) Law 2016 (from P.79/2016) ("the Capacity and Self-Determination Law") were adopted by the States Assembly on 13th and 14th September 2016 respectively. Both Laws are due to come into force on 1st October 2018.

2. The purpose of the Mental Health Law is to ensure that the provision of mental health services is underpinned with an up-to-date, legal framework which safeguards the rights, dignity and wellbeing of people experiencing mental health problems[1].

3. The purpose of the Capacity and Self-Determination Law is to provide a legal framework for assessing whether a person has capacity to make a decision if they are supported to do so. If a person does not have capacity to make a decision with support, then the Law provides a number of processes to ensure that any decision made for the person is made by an appropriate person and in the person's best interests[2].

4. A number of Regulations which underpin both Laws were lodged by the Minister for Health and Social Services on 27th February 2018.

5. A Project Team (comprising officials within the Health and Social Services Department ("HSSD"), the Law Officers' Department, the Law Draftsman's Office and the Chief Minister's Department) undertook an extensive consultation process when both Laws were in development. The Regulations also went through a consultation exercise, albeit through targeted stakeholders.

6. The Panel received 2 briefing sessions on the draft Regulations from Officers from both the Law Officers' Department and the HSSD. The Officers also helpfully provided the Panel with background documentation, and answered a series of written questions regarding the specific Regulations, which can be found in **Appendix 1**.

7. The information provided by the Departments has assisted the Panel in formulating these Comments.

The Regulations

8. There are 6 sets of draft Regulations and a Law amendment which underpin both the Mental Health and Capacity and Self-Determination Laws. These comments briefly explain each set of Regulations and where no issues have been found, no further comment is made.

[1] Draft Mental Health (Jersey) Law 201-, P.78/2016, p.6
[2] Draft Capacity and Self-Determination (Jersey) Law 201-, P.79/2016, p.6

P.43/2018: **Draft Capacity and Self-Determination (Capacity and Liberty – Assessors) (Jersey) Regulations 201-**

9. The Capacity and Self-Determination Law (Part 5) creates a process for authorising the provision of care to persons who lack the capacity to consent, and where their care needs are to be provided in circumstances that, by necessity, include significant restrictions on the person's liberty. This process will ensure that significant restrictions on a person's liberty are justified, proportionate and capable of being challenged[3]. Even when such restrictions are necessary to protect a person from harm, the basis for depriving someone of their liberty must be authorised[4].

10. Under Part 5, providers of health and social care services will be required to request an assessment from a registered care professional (who may among other things be a social worker, nurse or doctor) if they think they will need to impose significant restrictions on a person's liberty in order to care for them in a way that protects them from harm. The registered care professional will assess whether a person has the capacity to consent to proposals made for their treatment and, if not, whether those arrangements would involve a significant restriction on liberty that is necessary and in the best interests of the person[5].

11. These Regulations, therefore, make provision for arrangements relating to the appointment of Capacity and Liberty Assessors to authorise significant restrictions on the liberty of any person residing in any environment where they may be provided with health and social care[6], as defined by the Law.

P.44/2018: **Draft Capacity and Self-Determination (Independent Capacity Advocates) (Jersey) Regulations 201-**

12. The Capacity and Self-Determination Law (Part 6) introduces the new statutory role of Independent Capacity Advocates ("ICA"). An ICA will be someone independent, with knowledge of the Law but who is not a lawyer. An ICA will be appointed to support a person who lacks capacity, and may be particularly important where the person has no family or friends who are able to represent their wishes and feelings[7].

13. These Regulations provide for the appointment of, and services to be provided by, ICAs to represent persons and their rights under the Law.

P.45/2018: **Draft Capacity and Self Determination (Supervision of Delegates etc.) (Jersey) Regulations 201-**

14. The Capacity and Self-Determination Law (Part 2) makes provision for the appointment of a lasting power of attorney and (in Part 4) makes provision for the Royal Court to make decisions on behalf of persons lacking capacity, and to appoint delegates to make a decision or decisions on behalf of such persons[8]. Article 36 of the Law contains powers for the States, by Regulations, to make provision to confer

[3] Draft Capacity and Self-Determination (Jersey) Law 201-, P.79/2016, p.6
[4] P.43/2018
[5] Draft Capacity and Self-Determination (Jersey) Law 201-, P.79/2016, pp.17–18
[6] Draft Capacity and Self-Determination (Jersey) Law 201-, P.79/2016, p.17
[7] Draft Capacity and Self-Determination (Jersey) Law 201-, P.79/2016, p.20
[8] Draft Capacity and Self-Determination (Jersey) Law 201-, P.79/2016, p.35

appropriate supervision, monitoring and investigation powers on a person or office for the purpose of their supervising and regulating attorneys and delegates[9].

15. Therefore, these Regulations ("the Supervision Regulations") will designate the Viscount as the person with responsibility for supervision of delegates and attorneys, and will include a power for the Viscount to charge a supervision fee where the Royal Court assesses, on the appointment of a delegate, that the delegate in question would benefit from supervision by the Viscount in the performance of that role.

P.42/2018: **Draft Capacity and Self-Determination (Amendment) (Jersey) Law 201-**

16. In preparing the Supervision Regulations (P.45/2018 above), it was acknowledged that Part 4 of the Capacity and Self-Determination Law did not provide sufficient *vires* for the imposition of fees by the Viscount where the Court deemed supervision necessary. Therefore, this amendment would amend Article 36 of the principal Law to provide the power for fees to be charged by the Viscount. Such fees will be charged pursuant to powers contained in the Regulations noted above (P.45/2018).

P.46/2018: **Draft Mental Health (Guardianship) (Jersey) Regulations 201-**

17. The Mental Health Law (Part 4) makes provision relating to applications for, and the receipt of, mentally disordered patients into guardianship. Guardianship provides a mechanism that, when compulsory powers have to be used, enables the option of providing care and treatment in the least restrictive setting, consistent with the patient's best interests and safety, whilst balanced with the need to ensure public safety. The appointment of a guardian for a patient will enable their welfare to be safeguarded while they continue to live in the community, facilitating the maintenance of packages of care and support that aim to meet the needs of the patient outside of the hospital setting.

18. These Regulations provide for, among other things, the general duties of private guardians (i.e. a person other than the Minister), the procedure for, and the duties of, those involved with the transfer of a patient from an approved establishment into guardianship, and vice versa. For example, the requirement for the opinion of a registered medical practitioner that a patient should be moved into guardianship from an approved establishment (e.g. the hospital).

P.47/2018: **Draft Mental Health (Independent Mental Health Advocates) (Jersey) Regulations 201-**

19. The Mental Health Law (Part 11) introduces the statutory role of Independent Mental Health Advocates ("IMHA"). An IMHA is a specially-trained professional who will support patients to understand their rights under the Law. The IMHA will achieve this by enabling patients to be part of the decision-making around their care and treatment, and by working alongside patients in order to support them to articulate their needs and wishes in respect of service provision.

20. The Regulations provide for the appointment of, and services to be provided by, IMHAs to represent patients and their rights under the Law.

[9] Draft Capacity and Self-Determination (Jersey) Law 201-, P.79/2016, p.16

21. In relation to these draft Regulations, the Panel was contacted by Independent Advocacy Jersey ("IAJ"), as they were concerned that the right to statutory mental health advocacy would not be available for informal (voluntary) patients. IAJ is a newly established body which has recently tendered for the provision of statutory IMHA services, The Panel understands that a permanent contract has not yet been awarded.

22. The Panel met with representatives from the IAJ on 20th March 2018 to discuss their concerns further.

23. The IAJ explained that users of mental health services sometimes experienced difficulties negotiating with mental health professionals in terms of ensuring that their own point of view was acknowledged.

24. The IAJ explained their concern that if access to IMHAs was not statutory for all patients, there was a risk that access would be denied to voluntary patients. A copy of the concerns expressed by the IAJ can be found in **Appendix 2**.

25. The Panel met with the Minister for Health and Social Services and his officers on 21st March 2018 to discuss the concerns raised by the IAJ. The Panel was advised that voluntary patients, who remain in an approved establishment for treatment voluntarily, will have access to general advocacy services, but it was not deemed appropriate to extend statutory advocacy rights to them because of the consensual nature of their receipt of treatment. The Panel was informed that the HSSD recognised the importance of general advocacy services to voluntary patients, would maintain those services for the remainder of this Medium Term Financial Plan ("MTFP") period, and was currently seeking funding to continue the service in the next MTFP.

26. The Panel was also advised that the restriction of statutory IMHA services to persons detained is enacted in Article 79 of the Mental Health Law, and not in the present Regulations. Therefore it is not possible to seek an amendment to the Law through these particular draft Regulations.

P.48/2018: **Draft Mental Health and Capacity (Consequential Amendment and Transitional Provision) (Jersey) Regulations 201-**

27. When the Mental Health and Capacity and Self-Determination Laws commence, certain consequential amendments to a range of existing legislation are required, together with transitional provision for the move from the Mental Health (Jersey) Law 1969 which is to be repealed, to the new legislation.

28. Therefore, these Regulations will make a series of minor amendments to existing legislation.

Conclusion

29. The Panel has been advised that a review group will be set up to keep both Laws and their associated Regulations under review after they are implemented. Therefore, the Panel is satisfied that the review group will suggest amendments to the Minister should they be required. In this regard, the Panel would like to highlight the concerns raised by IAJ and seek the Minister for Health and Social Services' assurances that their concerns will be explored by the review group.

APPENDIX 1

Responses to the Health and Social Security Scrutiny Panel's questions on draft Regulations to be made under the Capacity and Self-Determination (Jersey) Law 2016 ("CSDL")

P.43/2018

What is the role of the assessors in summary?

Part 5 CSDL provides for imposing significant restrictions on the liberty of persons in relevant places (e.g. hospital, care homes) who lack the capacity to consent to those arrangements, and where the significant restrictions are required in the interests of that person's health or safety. For the purposes of responses to P.43 questions, that person is referred to as "P".

Where the Manager of a relevant place determines that P lacks capacity to give consent to care or treatment arrangements in the relevant place and that, for those purposes, P is or will be subject to restrictions on liberty (which are elaborated on in Article 39 CSDL), the Manager must notify the Minister requesting an assessment to be carried out. That assessment will be carried out by a designated assessor (assessors to be designated and selected by the Minister under the CSDL and the draft Regulations). The purpose of the assessment is to determine the matters at Article 44(6), which include whether the proposed restrictions amount to a significant restriction on liberty. The assessment enables the assessor to provide the Minister with a report (confirming the matters in Article 45). The Report will be either affirmative or negative. Affirmative reports (affirming the matters at Article 45(2)) will enable the Minister to authorize the imposition of significant restrictions on the liberty of P (see Article 48(1) and (2)). A negative report will prevent the Minister from granting authorization for the imposition of restrictions (see Article 46(1)). This process is the 'standard authorization' process. Assessors are also involved in requesting 'urgent authorizations' (see Article 42), which apply when there is a more immediate need to impose restrictions and where waiting until the standard authorization process is complete would not be appropriate. The standard authorization process must, nevertheless, be applied to P and, any authority to restrict P under an urgent authorization, will only last for 28 days, or until a standard authorization is granted or a negative assessment report provided to the Minister.

In essence, the rationale for the Part 5 CSDL process, the authorization of restrictions on liberty, and the role of assessors, is to ensure the Article 5 and 8 ECHR rights of persons lacking capacity and who cannot consent to arrangements are protected. Any imposition of restrictions on liberty will, following the application of the Part 5 CSDL processes, reflect a methodical application of measures, in accordance with law, which balance the right to liberty against the need to lawfully detain persons suffering incapacity.

Why not treat under the Mental Health Law?

Some vulnerable persons will most appropriately be detained for assessment and treatment under the powers provided under the MHJL. A person who lacks capacity would not be treated under the MHJL unless they have a diagnosed mental disorder that requires treatment. For example, a person with learning disabilities does not have a 'mental disorder' for the purposes of Part 3 of the MHJL, which enables the compulsory

detention and treatment of patients. The MHJL will only include a learning disability if that condition is associated with 'abnormally aggressive or seriously irresponsible conduct' on the part of the person.

A person with a learning disability or degenerative condition, although not detainable under the MHJL, might still require restrictions on liberty as part of their care and treatment for their own health or safety. For example, a restriction on someone with dementia could include deciding on the person's routine, stopping them from walking about at night, or preventing them from leaving the care home.

The choice between the powers in the MHJL and the CSDL are about assessing the person in all the circumstances and considering what is in that person's best interests, the interests of others, and also what is the least restrictive approach.

Who are the designated registered persons and how are they to be designated?

Article 40(1)(a) provides that for the purposes of assessments to be carried out in accordance with Part 5, the Minister must designate 'registered persons' to act as assessors. 'Registered persons' is defined in Article 37(1) as having the same meaning as is given to that expression by Article 1 of the Long-Term Care (Jersey) Law 2012 ("the 2012 Law"). Article 1 of the 2012 Law defines 'registered persons' as a registered medical practitioner under the Medical Practitioners (Registration) (Jersey) Law 1960 or a person in a registrable occupation under the Health Care (Registration) (Jersey) Law 1995.

Requirements for registration as a medical practitioner are set out in the Medical Practitioners (Registration) (General Provisions) (Jersey) Order 2014 (see Article 5 and the Schedule, in particular).

A 'registrable occupation' are those specified in the Schedule to the Health Care (Registration) (Jersey) Law 1995. That list includes social workers, clinical psychologists, nurses.

What qualifications must they hold and what training will they have?

CLA training has been designed for learners with 2 years' post-qualification experience, who are registered professions qualified in one of the following practice areas –

- Clinical Psychologist
- Occupational Therapist
- Registered Nurse (first level)
- Social Worker
- Speech and Language Therapist.

Regulation 2(4): How? Practical issues? Availability of interpreters?

This Regulation reinforces Article 3(1)(b)(i) CSDL, which ensures that a person is not treated as unable to make a decision unless all practicable steps to enable that person to make the decision have been taken without success. Engagement with persons lacking capacity is essential, as they must be supported in understanding and communicating around the decisions and matters with which they are faced, if they are to be properly represented.

Where assessments are legally challenged, measures taken under Regulation 2(4) will strengthen the Minister's evidence of application of the core principles in the CSDL around supporting persons to make decisions. This should have a correlated effect of limiting challenges to a determination of incapacity on the basis that such principles were not followed (those principles are a legal precursor to establishing a lack of capacity).

Regulation 2(4) explicitly provides that the Minister is obligated to provide cultural, ethnic and disability specific assessors "so far as practicable and as the Minister considers reasonable". Regulation 2(4) reflects the importance placed on this principle and requires the Minister to endeavour to ensure that cultural, ethnic and impaired persons have access to assessors who can carry out assessments in their specific cases.

Regulation 4(3): Has any code of practice or guidance been issued or prepared? Article 68 of the Law makes a code mandatory.

Codes of Practice have been prepared for both Laws, and professional consultation is underway. Public consultation will commence once the Regulations have been adopted.

P.44/2018

The services provided by ICAs seem limited to their duties under Articles 51, 64 or 65. What is the effect of this?

The ICA will carry out a specific role and this role is defined, rather than limited, by the Law. The circumstances are those where important health and welfare decisions need to be made by, or on behalf of, a person who may lack capacity (see Article 51, 64 and 65). In turn, those circumstances are: where P lacks any other support or representative and it is proposed to impose significant restrictions on that person's liberty under Part 5 CSDL; where P lacks any support or non-professional representatives and serious medical treatment is proposed in relation to P to which he or she lacks the capacity to consent; where P lacks any support or non-professional representatives and there are proposals as to the accommodation (or change to that arrangement) of P in a hospital or approved care home and P lacks capacity to consent to such arrangements.

A person who is compulsorily detained under the MHJL is entitled to seek the help of an IMHA. A person who is otherwise in care or in the community will have access to ICAs if they come within the circumstances set out in the CSDL, i.e. where there is an absence of other support for that person, and important decisions affecting that person need to be made. The role of IMHAs and ICAs in this sense ensures that the most vulnerable persons have access to advocacy services. Note that the CSDL will enable people to appoint lasting powers of attorney or, in the absence of that arrangement, the Court may appoint delegates to make health and welfare decisions on behalf of a person who loses capacity to make decisions in relation to matters which might include the receipt of types of care or treatment. That, in itself, is a safeguard for those who lose capacity, and the ICA function is designed to complement and, in specific cases, enhance the safeguards of the person's rights.

Regulation 2(1): What are the arrangements?

The Minister may appoint ICAs directly or contract (through a service level agreement) with service providers to provide ICAs. There is a current Service Level Agreement in place. There is also a procurement process underway.

Regulation 2(2): How does the Minister ensure that services are provided by qualified persons when using a provider?

The service level agreement entered into between the Minister and the service provider must include a requirement that the provider is satisfied, in making the appointment of ICAs, that the individual fulfils the conditions in Regulation 3. Regulation 7(1)(b) provides that where an ICA ceases to fulfil the conditions for appointment, in the case of an ICA appointed by a provider, that provider must terminate the provision of services by that ICA. A provider who continues to offer the services of such an ICA, in breach of Regulation 7(1)(b), commits an offence.

The service level agreement entered into with providers will, it is intended, contain reporting obligations, so that the Minister is kept informed of the provision of services by the providers.

Regulation 2(4): How? Practical issues? Interpreters?

This Regulation will be utilised in conjunction with Article 3(1)(b)(i) of the primary Law. This strengthens the ICA's ability to execute the core principles in the primary Law. The strengthening of practicable steps through the Regulation will ensure that practical issues cannot be a consideration, and will ensure compliance with the standards expected when decision-making for vulnerable citizens.

Regulation 3(1): What sort of experience is required? Code of practice?

This will be specified in the Code of Practice. There are prescribed qualifications for ICAs available from City & Guilds. ICAs must have achieved these, or be working towards them.

Regulation 4(2)(c)(iii): Is the reference to P a reference to the qualifying person?

Yes.

Regulation 5: How would ICA challenge and what resources available? How far does this go? Is there legal capacity in the ICA? What if ICA employed by a provider? Does this Regulation satisfy Article 63(2)?

Regulation 5 provides that an ICA may challenge a decision made under the Law, including a decision as to lack of capacity as if the ICA were a person caring for or otherwise interested in the qualifying person's welfare. The ICA has, therefore, a very wide remit to challenge decisions made in relation to the qualifying person, and would be equivalent to the right of relatives, for example, to challenge decisions. The process of how the ICA challenges is a practice matter. Where serious medical treatment is proposed, an ICA must be allowed to challenge the administration of that treatment in the same way a relative would be able to. In the case of a qualifying person subject to the significant restrictions, an ICA can challenge the Minister's authorization through

the Mental Health Review Tribunal (see Article 55(1)(b)(ii)). Persons aggrieved by decisions of the Tribunal may appeal to the Royal Court (see Article 58(1)).

The ICA is not the decision-maker but can use the power to challenge to uphold P's Article 5 and 6 human rights as detailed in the European Convention of Human Rights. Following the process to its ultimate conclusion, this would result in a legal determination of the capacity matters.

ICAs may make representations to the Mental Health Tribunal (no specific right of audience is required) but ICAs do not, by virtue of that role, have rights of audience in the Royal Court. An ICA could, in representing the interests of the qualifying person, be consulted in the preparation of any application to the Royal Court.

The ability for an ICA to challenge decisions in relation to a qualifying person is not impacted by whether they are appointed by a service provider or by the Minister directly.

Article 63(2) provides that Regulations *may* make provisions as to the circumstances win which ICAs may challenge, or provide assistance for the purpose of challenging, any decision under the Law affecting P or P's best interests. Regulation 4(1) provides ICAs, when appointed, must determine how best to represent P's interests and, under Regulation, have all rights and powers that a relative would have in supporting the qualifying person to challenge decisions made in relation to P.

Regulation 8: Are fees to ICAs employed by providers?

No. This would be managed through salary.

P.45/2018 and P.42/2018

Noted that delegates will be supervised to some extent by the Viscount. Has an agreement been reached on precisely how the Viscount will undertake her duties? What budget and resources are available? What might be the value of "a check-in phone call on a monthly or quarterly basis"? Will delegates be required to file annual accounts?

The Viscount has been fully consulted on the supervisory role and understands the functions and powers proposed to be ascribed to that role by the Regulations. The Viscount will perform the supervisory role in accordance with the Regulations, and has recruited additional staff specifically to accommodate this role within the department.

It is proposed there will be 2 'levels' of supervision that may be imposed on a delegate: 'basic' and 'enhanced'. The detail of the levels of supervision, and what is entailed and expected for each, are being finalised. In the case of 'basic' supervision, the intention is that the Viscount would perform a light-touch level of supervision, involving occasional engagement with the delegate and P: for example, yearly case review and reactive advice to the delegate or collecting reports from the delegate and random visits.

Article 34(8)(b) CSDL provides that a delegate may be required to provide to the Court, or to such other persons as the Court may specify (which in most cases would be the Viscount) such reports at such times or intervals as the Court may direct. Regulation 12(1)(a) enables the Viscount to require reports from delegates for the purposes of its functions under Regulation 2. Regulation 2(3)(a)(ii) also enables the

Viscount to request reports as part of an investigation into the conduct or performance of the delegate functions. Delegates may be required to provide annual accounts, or more frequent reporting, depending the circumstances of each case.

Regulation 3: Might there be instances where the Viscount cannot receive a complaint because it may relate to a matter in which the Viscount has been involved exercising supervisory powers. What happens?

The Viscount is entitled, and is expected to be able, to receive complaints regarding any delegate appointment should the circumstances dictate. If the Viscount has been involved in supervising a delegate, but the delegate still breaches his or her authority for example, a complaint can, and should, still be made to the Viscount. The Viscount can then look to address that complaint as part of the supervision process, or if the complaint is necessarily serious, make an application to the Court for revocation of the delegate's powers. The supervisory and investigatory roles are distinct.

The Viscount is exempt from Regulation when performing the role of delegate of last resort (see Regulation 16(1) – the Viscount cannot regulate itself), but nothing in the Regulations shall be taken to restrict the right of any person, on behalf of P, to make a complaint to the Viscount or to the Court in respect of any default or neglect in the performance by the Viscount of the Viscount's function of delegate (Regulation 16(3)).

Regulation 3(3): Noted the Viscount gives notice, but can she apply to the court for emergency orders without notice?

Rules of Court around the CSDL and the Regulations are in the process of being developed. There is nothing in the Law that would restrict the applications to the Court for applications for orders to be made without notice to the delegate or P.

Regulation 5(7): Does this limit the Viscount's powers to consult to cases where a complaint is made rather than cases where the Viscount acts under Regulation 3(2)

Yes.

Regulation 6: May we run through procedures if P is reinstated and wishes to know how a delegate has dealt with his affairs; also if P dies and family wish to know the same?

Delegates are to be appointed for such duration as reasonably necessary having regard to all the circumstances of P's case (Article 24(3)) (e.g. because a lack of capacity is known to last for a reasonably determinable period) or a delegate appointment might come to an end because P dies or regains capacity, for example.

Regulation 6(1)(d) and (2) provide that where a delegate ceases to be under a duty to discharge his or her function as delegate because, for example, P has regained capacity, the delegate must notify the Viscount of the discharge. The Viscount *may* then require the delegate to provide a final report on the exercise of the delegate's function. That report would be made available to P. Where P has died, a similar process would apply, and the report may be made available to family (depending on the circumstances applicable in each case).

Regulation 6 mostly concerns delegates. What of attorneys?

Delegates are appointed by the Court to act on behalf of someone else. Where that appointment comes to an end, it is right that the Viscount, in her supervisory function, should be able to determine the efficacy of the delegate's performance in that role, as it amounts to a review of a Court appointment.

By contrast, a lasting power of attorney is appointed by an individual directly. There is no government or 'state' involvement in that arrangement other than the requirement for the lasting power of attorney instrument to be registered with the Judicial Greffe. There is no basis on which the Viscount should be able to require a report on the performance of an attorney as it is a private arrangement (and Article 8 ECHR rights are engaged), other than in cases where a complaint arises or there are concerns, in which case the Viscount's jurisdiction applies.

Regulation 7(2): Consideration of P's best interests. This seems to be the paramount consideration, but what if fraud committed by the delegate/attorney?

Best interests are important in capacity matters, but as fraud would not be considered in P's best interests, there would clearly be grounds for applying to Court.

Regulation 11: Is there a further appeal?

Viscount's decisions may be judicially reviewed.

Regulation 14: Is this about making single decisions about treatment?

No, supervision arrangements imposed under Regulation 24 can apply to single decisions, or series of decisions, in relation to health and welfare or property and affairs matters.

Regulation 15(4): What happens if assets exist but are not liquid?

The Viscount has, it is expected, experience of enforcing judgments against illiquid assets so should apply normal procedures in such a case.

Regulation 15(7): What if P not eligible for Income Support or Long-Term Care because of less than 5 or 10 years' residence?

The rule in Regulation 15(4), and the interpretative provision in Regulation 15(7), is provided as the bar for automatically qualifying for exemption to supervision fees. It provides certainty in the scheme of the legislation. If P is not eligible for being deemed in receipt of qualifying benefit under Regulation 15(7), but the imposition of a supervision fee would cause undue hardship, the Viscount may determine that the fee is to be reduced by such amount as the Viscount deems fit (Regulation 15(5)).

Regulation 16: Is there supervision of the Viscount acting as delegate? How can a complaint against the Viscount be dealt with independently without commencing legal proceedings?

No. Supervision is intended to be applied in cases where the circumstances of the delegate, or P, require close support and supervision. That might be because the delegate appointed by the Court might need assistance in understanding delegate functions, or limits of authority. The Viscount will not need that supervision and, as a Court officer, would not expect to need to be supervised to perform a statutory function.

If a complaint is made against the Viscount about the Viscount's performance of a statutory function, it would be investigated in the same way as any other public authority would be investigated for failings in performing statutory functions.

Regulation 17: Would the Viscount incur liability for negligent acts or omissions?

The Viscount will incur liability for acts done, or omissions, in bad faith (see Regulation 17(2)(a)). That liability is in line with other provision in Law around the liability of government bodies performing statutory functions (see Article 48 of the Bankruptcy (Désastre) (Jersey) Law 1990.

See also Regulation 16(3) – nothing in the Regulations prevents complaints to the Viscount or the Court for default or neglect on the part of Viscount.

Regulation 18: Scale fees by reference to a percentage of P's assets? Is this appropriate?

The details around professional delegate fees are to be specified in an Order, further to proposed consultation with the industry. It is intended that setting fees by reference to a scale of assets would be retained (that system had, we understand, generally worked to an acceptable standard for curatorships). We are aware of concerns around the charging of professional fees associated with acting as curator, and we are exploring models to address that under the delegate system by imposing checks and balances implemented through the Order.

Note that the list of matters in Regulation 18(2) are without limitation to the general *vires* in Regulation 18(1) to make an Order as to delegate fees.

Regulation 22: Is a transition plan being prepared. Are all stakeholders involved and ready?

The Viscount, the Judicial Greffe and HSSD were all involved in agreeing the proposals for transitional arrangements. HSSD are working with the Viscount in preparing training for staff members.

Responses to the Health and Social Security Scrutiny Panel's questions on draft Regulations to be made under the Mental Health (Jersey) Law 2016

P.46/2018

Generally, in what circumstances might private guardians be appointed? Is it a role for family members? Can a non-natural person be appointed guardian?

Guardianship is used to help and encourage compulsorily detained patients get the care they need outside of hospital. A patient might be placed under guardianship even though they have mental capacity to make certain decisions, because it is felt the patient is vulnerable owing to a mental disorder. The choice of guardianship would be made instead of the patient being detained in hospital for treatment.

The Minister is often the guardian, but family members or other parties concerned with the welfare of the patient may also take on the role. Article 29(7) provides that a guardianship application, if naming someone other than the Minister as guardian, must contain a statement that the person so named consents to act as guardian in relation to the patient. Guardianship applications are determined by the Minister.

Regulation 2(8): Has a code of practice *re* care plans been issued or drafted?

A code of practice has been prepared and professional consultation has commenced. Public consultation will commence once the Regulations have been approved. Requirements for maintenance of care plans would be a practice decision, with guidance and support given to the guardian if deemed a necessary function in providing care to P.

Regulation 5 and Article 29: Noted that applications are to be made by an authorized officer. Article 6 of the Law provides that the Minister will prescribe the training and experience required to act as such. Has this yet been prescribed?

The current provision is via the Approved Mental Health Practitioner model, which involves training centred around English legislation and practice. The Project Team are developing Jersey-focussed training packages which centre on Jersey legislation. This is an extensive piece of work given the nature of the authorized officer role (equivalent to AMHPs) and their powers in the Law. Training will be an extensive undertaking for staff, with the proposed course lasting 4–6 weeks. The Project Team is seeking to have the training accredited by City and Guilds. Both the authorized officer and capacity and liberty assessor training is at post-graduate Masters level. A ministerial Order specifying the training and experience requirements of authorized officers has been drafted for implementation in October.

P.47/2018

Regulation 2(1): What are the arrangements?

There is a current Service Level Agreement in place. There is also a procurement process underway. The Minister also has a power to appoint Independent Mental Health Advocates (should the exercise of that power be deemed necessary) to ensure continuous provision of IMHA services.

Regulation 2(2): How does the Minister ensure services are provided by suitable persons when using a provider?

See response to equivalent question in responses to P.44/2018.

Regulation 2(4): How? Practical issues? Interpreters?

See response to equivalent question in responses to P.44/2018. Note also that IMHAs will have the same access to resources to assist with communication as the MH Tribunal and other assessors.

Regulation 3(1): What sort of experience and training is required? Code of practice?

There are prescribed qualifications for IMHAs available from City & Guilds. IMHAs must have achieved these, or be working towards them.

Regulations 4 and 6: If the qualifying patient is unable to make a request, why only the responsible person can make the request? Why not the nearest person?

The relationship between P and the nearest person may be such that the nearest person should not have access to all relevant information, at P's request not to share. Whilst P may be given compulsory treatment for mental health conditions, which would be a justifiable engagement of their Article 5 and 8 ECHR right in that regard, all other aspects of the patient's human rights must be guaranteed within the scope of the ECHR, in particular the patient's Article 8 ECHR right to privacy. The Regulations, Codes of Practice and associated training gives the responsibility to request IMHA services firmly to the responsible person as part of their professional role. This also precludes the eventuality where P's nearest person may not be benign (unknowingly to services), with potential resulting impact on the patient's right to privacy.

Regulation 7: What resources available to IMHAs aside from contractual fees? Can they commission research or legal advice?

The role of the IMHA is professional in nature, such as preparing Tribunal reports. This question highlights the necessity for professional IMHA services, which will be managed via the Service Level Agreement. As a professional role, the IMHA will be skilled in carrying out research and other functions as would be expected in the role.

Regulation 7(4): What if dispute between IMHA and attorney / delegate *re* production of records?

The delegate/attorney is P's appointed legal decision-maker, whether appointed by the Court (in the case of a delegate) or by P (in the case of an attorney). In matters of a dispute, so long as the delegate/attorney is acting within their authority, the decision of the delegate/attorney is to be taken as the decision of P, i.e. it would be treated as if P himself or herself said no. It is a breach of P's human rights to waive consent, and the IMHA should not have access to the information. This is the same for any other professional working with a delegate/attorney.

Regulation 10: Fees to IMHAs employed by providers?

No. This would be managed through salary.

APPENDIX 2

Submission by Independent Advocacy Jersey

Independent Advocacy Jersey, previously Mind Jersey, are concerned that, in the revised Regulations, the right to statutory independent specialist mental health advocacy has been removed for informal patients who are admitted to hospital. This means that the services of IMHAs will only be available, as a right, for detained patients.

We are aware that this follows what has happened in England, but would refer the Minister to the law in Wales which specifically sets out that –

> WELSH STATUTORY INSTRUMENTS
>
> 2011 No. 2501 (W.273) MENTAL HEALTH, WALES The Mental Health (Independent Mental Health Advocates) (Wales) Regulations 2011)
>
> *"the LHB must make arrangements for IMHAs to be available to Welsh qualifying informal patients who are present in a hospital or registered establishment located within the area of the LHB when the independent mental health advocacy service is to be provided".*

The responsibilities of Independent Mental Health Advocates ("IMHAs") in Wales are greater than those that apply in England as a result of these amendments. The Act places a duty on the Welsh Ministers to make arrangements for help to be provided by IMHAs. Such help must be made available to 2 client groups: Welsh qualifying compulsory patients, and Welsh qualifying informal patents.

In our experience, users of mental health services can experience difficulty negotiating with mental health professionals and ensuring that their own point of view is acknowledged. These difficulties apply both to the practical activities of daily life as well as help with their mental health problems. Service users sometimes have insufficient information about their mental ill-health and the various alternatives which may be available to them in relation to their treatment and care. Advocacy seeks to address this imbalance by ensuring that the service user's voice is heard, that they are able to make informed choices, and that their rights are safeguarded.

Evidence shows that advocacy can lead to an improved experience of mental health services for individuals, including "the potential for advocacy to secure basic rights; create choice; improve the identification and understanding of mental health needs; promote self-advocacy and involvement in decision-making; challenge discrimination; and promote access to complimentary ways of healing and practical help".

A major study in to the role and value of IMHAs gave evidence that access to IMHAs reduces the level of hostility and aggression on wards – patients feel less alone, frustration and fear can be resolved at an early stage, and they feel treated with respect.

The Welsh Government states that it is committed to working with services to ensure that advocacy is available for individuals at times when their mental health and usual support mechanisms may be breaking down, leaving them vulnerable when key decisions about treatment and support may need to be made.

In asking for Jersey's government to include statutory advocacy services so that access is available to the majority of inpatients receiving treatment for mental ill-health, whether subject to compulsory powers or not, IAJ is seeking to ensure that the rights of this often vulnerable group of patients are safeguarded. The expanded independent mental health advocacy scheme will assist inpatients in making informed decisions about their care and treatment, and support them in getting their voices heard.

Advocacy can ensure that all patients are listened to and that their voice is heard. IMHAs ensure that patients are aware of their rights, where patients are detained that this is lawful and that they have access to appeal and to legal support, that the provision of services is transparent and that any restrictions imposed on patients are proportionate and necessary. It is not appropriate for service providers to gate keep the service as the groups who are in many ways the most vulnerable are those who are least willing and/or able to question or challenge. Evidence shows that the very young, the elderly, people with education which stopped prior to degree level, people for whom English is not a first language, and those is abusive relationships are the least likely to seek to access their rights.

If access to IMHAs is not statutory for all, it is inevitable that over time that such access will be denied to informal patients. IAJ is deeply concerned that informal patients will be denied this independent and supportive specialist service at a time when they are at their most vulnerable.