



Mental Health (Jersey) Law 2016

Code of Practice

The cover and associated artwork comes from 'Arts Exploration' and 'The Art Group'. These groups support individuals affected by both capacity and mental health issues. Thank you to the group members who shared their work.

The cover was chosen from a selection of works by public focus groups and professionals. A selection of the submitted artworks are showcased at the end of the Code of Practice.

Thank you to the artists who have allowed us to use their creativity and personal interpretation of their experiences of mental health and capacity issues which is reflected in their artwork.

Code of Practice Development Group Membership

Ian Dyer, Mental Health Law/Capacity and Self-Determination Law Policy Lead

Kellie Goldsworthy, Mental Health Law/Capacity and Self-Determination Law Project Manager

Toby Farlan, Social Worker, Capacity and Liberty Officer

Bradley Chambers, Social Worker, Authorised Officer

Marion Walton, Mental Health and Capacity Law Administrator

Frank Le Gros, Legal Advisor

Joseph Matia, Legal Advisor

Dr Miguel Garcia, Consultant Psychiatrist

Acknowledgements

The Development Group and Health and Community Services would like to thank the members of the public and service users who attended the Jersey Consumer Council presentations, attended focus groups and gave invaluable feedback and comment, and those professionals who acted as advisers on specialist topics or have contributed to the process by reviewing drafts of the Code of Practice.

Ministerial Foreword

The decision to introduce the Mental Health (Jersey) Law 2016 was taken as a result of the need to reflect modern standards for the diagnosing and treating of persons with mental disorders. The new legislation forms part of a fundamental reform in the intervention and approach of organisations and individuals in how they work with and support some of the most vulnerable people in Jersey.

Whilst much of the provision of the new Law mirrors equivalent legislation elsewhere across the British Isles, the new Law is formed around the specific needs of the island. The Code of Practice which accompanies the Law has been devised following extensive consultation with service users, carers, professionals and other stakeholders. Our ambition is that the resulting document reflects the needs and expectations of those who are most affected by the provision of mental health services in Jersey.

The Law is underpinned by five guiding principles. Each are of equal importance and the principle of empowerment is as critical as is that of purpose and effectiveness. The balance between keeping people safe from harm whilst ensuring that people are able to make and take responsibility for their own decisions is complex and will continue to present a challenge to staff and services. To detain a person in hospital is never an easy decision to make. It is therefore essential we engage in those critical debates pertaining to an individual's right to self-determination whilst balancing this against the need to protect individuals and members of the public. The Code of Practice is at the heart of that balance.

In ensuring that the Code is made widely available in a variety of appropriate formats, I am confident that alongside modernisation and reform there will exist an improved sense of transparency and accountability. Similarly the provision of statutory independent advocacy services will deliver a means of ensuring that those who are most vulnerable and most at risk of not being heard have greater opportunity to make their needs, views and wishes known. Such measures are intended to ensure that service users and carers remain firmly at the heart of decision-making processes.

Deputy Richard Renouf

Minister for Health and Community Services

Contents

Contents

Introduction

Executive Summary

Glossary	1
----------	---

Section 1: Application of the Law

Chapter 1	The Five Guiding Principles	8
Chapter 2	Human rights and equality	13
Chapter 3	Mental Disorder	16

Section 2: Protecting the rights and autonomy of patients

Chapter 4	Information for patients, the Nearest Person and others	25
Chapter 5	Confidentiality and information sharing	32
Chapter 6	Role and function of Nearest Persons and nominated persons	38
Chapter 7	Independent Mental Health Advocates (IMHA)	48
Chapter 8	Privacy, safety and dignity	54
Chapter 9	Visiting patients in hospital	63
Chapter 10	Wishes expressed in advance	67
Chapter 11	The Mental Health Review Tribunal	71

Section 3: Assessment, Transport and Admission to hospital

Chapter 12	Applications for detention in Approved Establishments	82
Chapter 13	Police powers and places of safety	99
Chapter 14	Conveyance of patients	106
Chapter 15	Holding powers	113
Chapter 16	Transfer of patients to and from other countries and territories	119
Chapter 17	Capacity and significant restriction on liberty	122

Section 4: Meeting the needs of specific patients		
Chapter 18	People with learning disabilities	134
Chapter 19	People with personality disorders	139
Chapter 20	Children and young people under the age of 18	144
Chapter 21	Patients concerned with criminal proceedings	159

Section 5: Care, support and treatment in hospital		
Chapter 22	The appropriate medical test	172
Chapter 23	Medical treatment	177
Chapter 24	Treatments subject to special rules and procedures	188
Chapter 25	Safe and therapeutic responses to disturbed behaviour	198
Chapter 26	Restrictive interventions	214

Section 6: Leaving hospital		
Chapter 27	Guardianship	236
Chapter 28	Leave of absence	243
Chapter 29	Absence without leave	249

Section 7: Professional Responsibilities		
Chapter 30	Functions of the department and Approved Establishment managers	255
Chapter 31	Receipt and scrutiny of documents	259

Introduction

The Mental Health (Jersey) Law, 2016 Code of Practice, hereto referred to as the Code will come into force in 2018. The Code is issued under Article 90 of Mental Health (Jersey) Law, 2016 (“the Law”).

It provides statutory guidance to medical practitioners; authorised officers; managers and staff of Approved Establishments as to how they should proceed when performing their duties under the Law. These professionals are required to have detailed knowledge of the Code, including its purpose, function and scope. Service providers not mentioned in this Code are responsible for obtaining their own legal advice in respect of any matter of uncertainty.

The Code has been prepared through consultation by and on behalf of the Minister with various agencies and other persons.

All staff are accountable to their employing organisation and their relevant professional body for any decisions they make regarding the treatment and care provided to people under the Law. Consequently, where staff make decisions under the Law, they are both personally and professionally accountable. The Code is not law but it exists to support and guide the implementation of the Law. As such, any departure from the Code must be clearly justified and recorded. It is acknowledged that any such departure might be referred to in legal proceedings.

Executive summary

The Mental Health (Jersey) Law 2016 Code of Practice (the Code), is a document intended for active use by professionals, patients, carers and members of the public. It provides statutory guidance in respect of how functions under the Mental Health Law must be carried out in practice. Additionally it provides statutory guidance to those treating patients for mental disorder.

The States of Jersey has a duty to ensure that the provision of mental health services remains appropriate, adequate, legal and effective. The Code is intended to support this provision. It is therefore essential that those for whom the Code is statutory guidance endure that they are familiar with its contents and with its requirements.

The Code is based upon the Mental Health Act: 1983 Code of Practice. However, there are significant differences between the two codes on account of the requirement to ensure that the Code reflects the context and experience of the provision of mental health services in a Jersey context. There are also distinct differences between the Mental Health (Jersey) Law 2016 and the Mental Health Act 1983 which have needed to be reflected in the Jersey Code.

Chapters have been grouped into seven sections. These are summarised below.

The application of the Law: chapters 1-3

This group of chapters set out the five guiding principles which underpin the Law, provide guidance on the definition of mental disorder and detail equality and human rights considerations under the Law.

Protecting the rights and autonomy of patients: chapters 4-11

The need to uphold the rights of patients, particularly those who are detained under the Law is paramount. This group of chapters detail the role and function of nearest persons, the considerations which must be made in relation to the sharing of confidential information and the role and function of Independent mental health advocates (IMHAs). These chapters provide guidance in respect of people who can represent or may have an interest in a patient's care and treatment. They provide guidance on the role and function of the Tribunal including the duty to inform patients and their nearest person about their rights of appeal to a Tribunal.

Assessment, Transport and Admission to hospital: chapters 12-17

These chapters address the legal framework which governs a patient's assessment and admission to an approved establishment. Guidance is provided in respect of applications for detention under the Law, including emergency detention and conveyance of a patient to an approved establishment. Guidance is also provided in respect of the Capacity and Self-Determination Law 2016 and the circumstances under which a significant restriction on liberty might be authorised instead of making an application under the Law.

Meeting the needs of specific patients: chapters 18-21

In addition to the general guidance provided by the Code, specific groups of patients have additional needs and requirements. The specific groups are people with learning disabilities, people with personality disorders, children and young people under the age of 18 and patients concerned with criminal proceedings. These are addressed in these chapters. The needs of people with autism spectrum disorders are addressed separately in chapter 5.

Care, support and treatment in hospital: chapters 22-26

These chapters address issues relating to the care and treatment of patients. Guidance is provided in respect of the appropriate medical test, medical treatment under the Law and on treatments which are subject to special rules and procedures under the Law. Specific guidance is provided in respect of safe and therapeutic responses to disturbed behaviour and in respect of the use of restrictive interventions.

Leaving hospital: chapters 27-29

This group of chapters provides guidance in respect of the use of Guardianship and leave of absence from an approved establishment. The use of indefinite leave of absence is a means of enabling patients to leave an approved establishment and to receive treatment in the community. Guidance is provided around its use. Additional guidance is provided in respect of the return of patients to an approved establishment in the event that they are absent without leave.

Professional Responsibilities: chapters 30-31

Hospital managers and others have specific roles under the Law. Guidance is provided in respect of these. Additionally, this group of chapters provides guidance on responsibilities in relation to the receipt and scrutiny of documents.

Glossary

ADRT	Advance Decision to Refuse Treatment (Part 3 Capacity and Self Determination [Jersey] Law, 2016)	This is a legal document which enables a person to state which types of treatment they do not want up to and including life-sustaining treatment. If an ADRT applies to a proposed treatment is must be adhered to. An ADRT will not normally apply to psychiatric treatment for a detained patient.
AE	Approved Establishment	These are places approved by the Minister (for Health and Community services) for the purpose of caring for and treating patients.
AO	Authorised Officer	This person 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.
AP	Approved Practitioner	This is a doctor with specialist training in relation to both mental health practice and in respect of the Mental Health Law who is approved by the Minister to carry out specific functions under the Law.
AS	Advance Statement – A record of a person’s wishes in terms of a specified treatment for their mental disorder that they do not wish to carried out, made at a time when they have capacity, to be applied at a time that they lack capacity and witnessed by a registered mental health professional	An AS is not legally binding in the way that an ADRT is. However, it should be adhered to wherever possible. An AS can specify the type of treatment a person would wish to receive or not receive and can apply to psychiatric treatment as well as physical treatment.
attorney		Someone appointed under a Lasting Power of Attorney (LPA) who has the legal right to make decisions within the scope of their authority as if they were the person (the donor) who made the LPA.
Attorney General		The principal legal adviser to the States of Jersey.
AWOL	Absent Without Leave	This refers to a detained patient who has left an Approved Establishment without permission.
CAMHS	Child and Adolescent Mental Health Services	This service provides assessment and treatment to children and young people experiencing mental distress.

Care Coordinator		This is a mental health professional who may either be a nurse, social worker, occupational therapist, psychologist or other specialist. Their role is to supervise interdisciplinary care of a patient, to co-produce a care plan with the patient and to monitor and oversee the care which is delivered, A Care Coordinator may work in both inpatient and outpatient settings.
carer		A carer is anyone who provides support to a friend or family member who due to illness, disability, a mental health problem or an addiction cannot otherwise meet their own needs without this support.
Court		In most cases throughout the Code, 'court' will refer to the Royal Court. However, there are exceptions to this as other courts have powers under the Law also. It is therefore necessary to consult the Law itself in order to determine which court is referenced.
delegate		A person appointed to make decisions by the Royal Court under Article 24 of the Capacity and Self Determination (Jersey) Law 2016
ECHR	The European Convention on Human Rights	The rights and freedoms guaranteed under the Convention form the basis of the Human Rights (Jersey) Law 2000 and are encapsulated within it.
GP	General Practitioner	A community-based doctor who treats patients with minor or chronic illnesses. He will refer patients with serious conditions to a hospital and patients with conditions requiring specialist intervention to a specialist team. A GP may not have specialist training in the treatment of mental illness.
IMHA	Independent Mental Health Advocate	This is an independent professional appointed by the Minister to support patients who qualify for the service. Their role includes supporting patients to express their own views and wishes in respect of their care and treatment and to ensure that their rights are upheld.
JMAPPA	Jersey's Multi-Agency Public Protection Arrangements	These arrangements were implemented in 2011 when the Sex Offenders (Jersey) Law 2010 came into force. The role of JMAPPA is to make arrangements in order to assess and manage sexual, violent and dangerous offenders, together with potentially dangerous persons. The purpose of JMAPPA is to protect the public by reducing the offending behaviour of sexual and violent offenders.

Nearest Person	The person defined by the Law or nominated by the relevant person as having specific rights in relation to the relevant person's care or treatment (refer to Part 2 of the Law)	Most patients will have a Nearest Person defined by the Law. The Nearest Person has a specified and important function. There is the facility to appoint a Nearest Person to a patient who does not have one and there is the facility for a patient to choose a different Nearest Person if they wish. This person is then known as the Nominated Representative.
Nominated Representative		This is a person nominated either by the patient or by the court to fulfil the role of the Nearest Person.
PBSP	Positive Behavioural Support Plan	This is a framework most often used to support people with learning disabilities (although similar alternative such plans may be used in other services). The purpose of such plans is to outline strategies that respond to the needs of the person and to the underlying causes of the challenging behaviour; how the use of restrictive practices may be reduced or removed altogether, and how the person's quality of life may be improved.
PPACE	Police Procedures and Criminal Evidence (Jersey) Law 2003 and Codes of Practice	These are rules which the police must follow. They outline how the police must act and the rights of people who are subject to police processes.
RMO	Responsible Medical Officer	The doctor responsible for a specific patient. The roles and responsibilities of the RMO may be delegated in situations where the patient's RMO is unavailable for an extended period.
SOAD	Second Opinion Approved Doctor	This is an independent doctor who is approved by the Minister to provide a professional opinion about the suitability of a particular treatment. Some types of treatment require the agreement of a SOAD before they can be undertaken or continued.
the Administrator	The Mental Health and Capacity Law Administrator	This person is responsible for the administration of both the Mental Health and Capacity and Self Determination laws. He ensures that associated documentation is available for use and is completed accurately. He is responsible for ensuring that reports for tribunals are completed promptly and accurately.
the Bailiff		This official is the President of the Royal Court. The Bailiff or his representative/s is responsible for issuing a warrant under Article 35 of the Law.
the Capacity Law	The Capacity and Self-Determination (Jersey) Law, 2016	This law has been introduced at the same time as the Mental Health Law. It includes provision for how a person's capacity should be assessed and how best interest decisions may be made.

the Children Law	The Children (Jersey) Law, 2002	
the Code	The Mental Health (Jersey) Law, 2016 Code of Practice	
the Convention	The European Convention on Human Rights	The Convention has been encapsulated into Jersey law in the form of the Human Rights (Jersey) Law 2000.
the Department	States of Jersey Health and Community services Department	
The Human Rights Law	The Human Rights (Jersey) Law, 2000	This law encapsulates the European Convention on Human Rights.
the Law	The Mental Health (Jersey) Law, 2016	
the Minister	The Minister for Health and Community services	
the Tribunal	Mental Health Review Tribunal	Detained patients and their Nearest Person have the right of appeal against the patient's detention. Such appeals are heard by the Tribunal. The Tribunal has a number of functions and has the ability to either uphold or to discharge a patient's detention.
Young person		A person aged 16 or 17 years old (a child is a person aged 15 years old or younger).

Capital letters are used and shown in this glossary as a guidance for replication.

A word or expression used in this Law and defined in the Capacity and Self Determination (Jersey) Law 2016 shall, unless otherwise indicated or required by the context, be taken to have the same meaning for the purposes of this Law as that word or expression is given in the Capacity and Self Determination Law.

Section 1: Application of the Law

Why read this section?

This group of chapters set out the five guiding principles which underpin the Law, provide guidance on the definition of mental disorder and detail equality and human rights considerations under the Law.



Chapter 1: The Five Guiding Principles

Chapter 1: The Five Guiding Principles

The Law is underpinned by five principles. These are:

Least restrictive option and maximising independence

- 1.1** Where it is possible to treat a patient safely and lawfully without detaining them under the Law, the patient should not be detained.
- 1.2** Commissioners, providers and other relevant agencies should work together to prevent mental health crises and, where possible, reduce the use of detention through prevention and early intervention by commissioning a range of services which meet the needs of the local population.
- 1.3** If the Law is used, detention should be used for the shortest time necessary for the purpose of ensuring the safety of a patient and others.
- 1.4** Any restrictions should be the minimum necessary to safely provide the care or treatment required having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person's rights and freedom of action.
- 1.5** Restrictions that apply to all patients in a particular setting should be avoided. There may be settings where there will be restrictions on all patients that are necessary for their safety or for that of others. Any such restrictions should have a clear justification for the particular place to which they apply. Universal restrictions should never be for the convenience of the provider. Any such restrictions, should be agreed by Approved Establishment managers, be documented with the reasons for such restrictions clearly described and subject to governance procedures that exist in the relevant organisation.

Empowerment and involvement

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

1

- 1.7 A patient's views, past and present wishes and feelings (whether expressed at the time or in advance), should be considered so far as they are reasonably ascertainable. Patients should be encouraged and supported to develop *advance statements* and *statements of wishes and feelings* to express their views about future care and treatment when they are well.
- 1.8 The patient's choices and views should be fully recorded. Where a decision in the care plan is contrary to the wishes of the patient the reasons for this should be transparent, explained to them and fully documented.
- 1.9 Patients should be enabled to participate in decision-making as far as they are capable of doing so. Consideration should be given to what assistance or support a patient may need to participate in decision-making and any such assistance or support should be provided, to ensure maximum involvement possible.

This includes being given sufficient information about their care and treatment in a format that is easily understandable to them.
- 1.10 Patients should be encouraged and supported to involve carers and significant others in decision-making processes (unless there are particular reasons to the contrary). Professionals should consider the views of these people when making decisions.
- 1.11 Patients and their carers should be informed of the support that an IMHA can provide, (or an independent capacity advocate (ICA) where relevant). The Department should ensure that information is available pertaining to access to support from IMHA/ICA services.

Respect and dignity

- 1.12 Patients and carers should be treated with respect and dignity. Practitioners performing functions under the Law should respect the rights and dignity of patients and their carers, while also ensuring their safety and that of others.
- 1.13 People making decisions under the Law must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, and culture. There must be no unlawful discrimination.

Purpose and effectiveness

- 1.14 Care, support and treatment given under the Law should be given in accordance with up-to-date guidance and/or current best practice from professional bodies, where this is available. Treatment should address an individual patient's needs, taking account of their circumstances and preferences where appropriate.
- 1.15 Patients should be offered treatment and care in environments that are safe for them, staff and any visitors. Such environments should be both supportive and therapeutic. Practitioners should deliver a range of treatments which focus on positive clinical and personal outcomes. Care plans for detained patients should focus upon recovery and ending detention as soon as possible. Commissioners, providers and professionals should consider the broad range of interventions and services needed to promote recovery not only in hospital but after a patient leaves hospital, including maintaining relationships, housing, opportunities for meaningful daytime activity and employment opportunities.
- 1.16 Physical healthcare needs should be assessed and addressed including promotion of healthy living and steps taken to reduce any potential side effects associated with treatments.


Efficiency and equity

- 1.17 Commissioners and providers, including their staff, should give equal priority to mental health as they do to physical health conditions.
- 1.18 Where patients are subject to compulsory detention, health and social care agencies should work together to deliver a programme of care that, as far as practicable, minimises the duration of detention, facilitates safe discharge from hospital and takes into account the patient's wishes and where appropriate the wishes of their carer/s.
- 1.19 Commissioners, providers and other relevant organisations should establish effective relationships to ensure efficient working with accountability defined through joint governance arrangements. Joint working should be used to minimise delay in care planning needed to facilitate discharge.
- 1.20 Commissioners, providers and other relevant organisations should ensure that their staff have sufficient skills, information and knowledge about the Law and provision of services to support all their patients. There should be clear mechanisms for accessing specialist support for those with additional needs.

1

Using the principles

- 1.21** All decisions must be lawful and informed by good professional practice.
- 1.22** All five principles are of equal importance, and should inform any decision made under the Law. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision. The guidance in the Code is based on these principles and reference is made to them throughout the Code.
- 1.23** Commissioners, providers, professionals and others providing care under the Law should document, and justify, any decision to depart from the Code or a particular guiding principle. Whilst it is acknowledged that occasions may arise when such departures are justified or warranted, it is anticipated that such departures would be few in number.



Chapter 2: Human rights and equality

Chapter 2: Human rights and equality

2.1 This Chapter highlights good practice in service delivery and professional practice in relation to the Law, which enhance and uphold the principle of equality and which protect human rights.

2.2 Commissioners and providers will need to consider the legislation and international conventions listed below.

- Human Rights (Jersey) Act 2000 (the Human Rights Law)
- Discrimination (Jersey) Law 2013
- United Nations Convention on the Rights of the Child
- Disability Strategy for Jersey (May 2017)
- European Convention on Human Rights (the Convention)

It is acknowledged that this list is not conclusive and that further relevant such legislation, conventions and policies may be issued after the enactment of the Law.

2.3 The Human Rights Law provides a framework for commissioners and providers to deliver the best possible outcomes for everyone who uses services. This means:

- putting human rights principles and standards into practice.
- aiming to secure the full enjoyment of human rights for all, and
- ensuring that such rights are protected and secured.

The duty to uphold these principles and standards extends to any third party carrying out public functions, including the delivery of public services by private and contracted-out providers.

2.4 The **PANEL** principles are one way of breaking down what a human rights based approach means in practice:

Participation – People should be involved in decisions that affect their rights.

Accountability – There should be monitoring of how people's rights are being affected, as well as remedies when things go wrong.

Non-discrimination and equality – All forms of discrimination should be prohibited, prevented and eliminated. People who face the biggest barriers to realising their rights should be prioritised.

Empowerment – Everyone should understand their rights, and be fully supported to take part in developing policy and practices which affect their lives.

Legality – expressly applying the Human Rights Law and linking to the Convention, international standards and laws.

- 2.5** The Human Rights Law gives certain rights and freedoms guaranteed under the Convention. The Human Rights Law places a duty on the Department to respect and protect people's human rights. This duty extends to any third party carrying out public functions, including the delivery of public services by private and contracted-out providers.
- 2.6** In some instances, competing human rights will need to be considered, which may require finely balanced judgements. Such decisions and the reasons for them should be clearly documented in a patient's record by whosoever takes a decision which has implications for a patient's human rights. Decisions restricting a person's rights will need to be justifiable as necessary and proportionate in the circumstances of the specific case.
- 2.7** The Discrimination (Jersey) Law 2013 makes it unlawful to discriminate (directly or indirectly) against a person on the basis of a protected characteristic or combination of protected characteristics, detailed in Schedule 1 of the Law.

The protected characteristics are:

- Race
- Sex
- Sexual orientation
- Gender reassignment
- Pregnancy and maternity
- Age.

Protection against disability discrimination will come into force on 1st September 2018.



Chapter 3: Mental Disorder

Chapter 3

Definition of mental disorder	17
Dependence upon alcohol or substances.....	18
Learning disabilities.....	19
Autism Spectrum Disorder (ASD)	19
Delirium.....	21
Self-harm.....	21
Suicidal ideation and intent.....	22

Chapter 3: Mental Disorder

3.1 This Chapter gives guidance on the definition of mental disorder for the purposes of the Law.

Definition of mental disorder

3.2 Mental disorder is defined for the purposes of the Law as “any disorder or disability of the mind”. Relevant professionals should determine whether a patient has a disorder or disability of the mind in accordance with good clinical practice and approved clinical definitions of what constitutes such a disorder or disability.

3.3 Clinically recognised conditions falling within this definition include:

- Affective disorders, such as depression and bipolar disorder.
- Schizophrenia and delusional disorders.
- Neurotic, stress-related and somatoform disorders, such as anxiety, phobic disorders, obsessive compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders.
- Organic mental disorders such as dementia and delirium (however caused).
- Personality and behavioural changes caused by brain injury or damage (however acquired).
- Personality disorders (see Chapter 19).
- Mental and behavioural disorders caused by psychoactive substance use (see paragraphs 3.6–3.9).
- Eating disorders, non-organic sleep disorders and non-organic sexual disorders.
- Learning disabilities (see paragraphs 3.10–3.11 and Chapter 18).
- Autism spectrum disorders (including Asperger’s syndrome) (see paragraphs 3.10–3.12).
- Behavioural and emotional disorders of children and young people (see Chapter 20).

(Note: this list is not exhaustive)

- 3.4** The fact that someone has a mental disorder is never sufficient grounds for any compulsory measure to be taken under the Law.
- 3.5** Difference must not be confused with disorder. No-one may be considered to be mentally disordered solely on the basis of their personal, political, religious or cultural beliefs, values or opinions unless there are genuine clinical grounds which indicate that they are the symptoms or manifestations of a disability or disorder of the mind. This equally applies to a person's involvement or likely involvement in illegal, anti-social or "immoral" behaviours.

Dependence upon alcohol or substances

- 3.6** Addiction to alcohol or substances does not fall within the scope of the Law although disturbances of the mind or brain borne out of such addictions may do. Consequently there are no grounds under the Law to detain a person or to use other compulsory measures on the basis of alcohol or drug dependence alone.
- 3.7** Alcohol or drug dependence may be accompanied by or associated with a mental disorder which does fall within the scope of the Law. If the relevant criteria are met it is therefore possible to detain and treat someone who is suffering from a mental disorder and is also dependent upon alcohol or substances. This is also the case if the mental disorder in question results from the person's alcohol or drug dependence.
- 3.8** The Law does not exclude other disorders or disabilities of the mind related to the use of alcohol or drugs. Examples include withdrawal state with delirium or associated psychotic disorder; acute intoxication and organic mental disorders associated with prolonged use of alcohol or drugs. These remain mental disorders for the purposes of the Law.
- 3.9** Medical treatment for mental disorder under the Law can include measures to address alcohol or drug dependence if that is an appropriate part of treating the mental disorder. However, the mental disorder must remain the primary focus of the treatment. It is not anticipated that detoxification without patient consent takes place. Such interventions are unlikely to produce positive outcomes for patients.

Learning disabilities

3.10 Learning disability is a form of mental disorder as defined in the Law. The needs of these patients are addressed more fully in Chapter 18.

3.11 A person with a learning disability and no other form of mental disorder may not be:

- detained under the Law
- be remanded to an Approved Establishment for a report of their mental condition
- be remanded to an Approved Establishment for treatment
- be made subject to or have renewed a hospital treatment order or be committed to the court for the making of such an order,

unless their learning disability is associated with abnormally aggressive or seriously irresponsible conduct on their part.

Equally, an application for a hospital transfer order cannot be made unless this additional qualification is met.

Autism Spectrum Disorder (ASD)

3.12 Autism Spectrum Disorder is a form of mental disorder as defined in the Law.

3.13 The Law does not provide a separate definition of Autism Spectrum Disorder in the way that it does in respect of learning disabilities. Resultantly it is possible for someone on the autistic spectrum to meet the conditions for treatment under the Law without having any other form of mental disorder (even if it is not associated with *abnormally aggressive* or *seriously irresponsible* behaviour). However, it is not anticipated that this will happen often, if at all. Compulsory treatment in an Approved Establishment setting is rarely likely to be helpful for a person with an autism spectrum disorder, who may be very distressed by even minor changes in routine and is likely to find detention in an Approved Establishment anxiety provoking. Sensitive, person-centred support in a familiar setting will usually be more helpful. Wherever possible, less restrictive alternative ways of providing the treatment or support a person needs should be found and compulsory admission should be avoided.

3.14 Autism spectrum disorders occur from early stages in a person's development in which the person shows marked difficulties with social communication, social interaction and social imagination.

- 3.15** These disorders are neurological and developmental in nature and are not mental illnesses in themselves. However, people with an autism spectrum disorder may experience additional or related challenges in relation to their ability to make sense of the world around them and to relate to others. Consequently people with an autism spectrum disorder may experience frustration or anxiety (or even anger and aggression). Such presentation may be related to communication problems or to patterns of thought and behaviour that are rigid or literal in nature. As with people with learning disabilities, it should be borne in mind that people with autism spectrum disorders may also have co-morbid mental disorders, including mood disorders and occasionally, personality disorders.
- 3.16** A person with an autism spectrum disorder may behave in ways that seem unusual to other people. However, mere eccentricity is not in itself a reason for compulsory measures under the Law.
- 3.17** There can also be a repetitive or compulsive element to much of the behaviour of people with autism spectrum disorders. The person may appear to be choosing to act in a particular way and their behaviour may be distressing even to themselves. It may be driven or exacerbated by anxiety and could lead to harm to self or others. Repetitive behaviour does not in itself constitute a mental disorder.
- 3.18** The examination or assessment of someone with an autism spectrum disorder requires special consideration of how to communicate effectively with the person being assessed. Whenever possible, the people carrying out assessments should have experience and training in working with people with these disorders. If this is not possible, they should seek assistance from specialists with appropriate expertise but this should not be allowed to delay action that is immediately necessary.
- 3.19** Where appropriate, someone who knows the person with an autism spectrum disorder should be present at the assessment (subject to the normal considerations of patient confidentiality). Knowledge of the person's early developmental history and usual pattern of behaviour is likely to be helpful in the assessment process.
- 3.20** A person with an autism spectrum disorder may show a marked difference between their intellectual and their emotional development. This difference may be associated on occasion with aggressive or seriously irresponsible behaviour. This should be understood and responded to by professionals, who should recognise that the nature of any communication difficulties may require specialist structured approaches to communication. However, when the person is unable to prevent themselves from causing severe harm to their self or others, compulsory measures under the Law may become necessary.

- 3.21** If people with autism spectrum disorders do need to be detained under the Law, it is important that they are treated in a setting that can accommodate their social and communication needs as well as being able to treat their mental disorder.

Delirium

- 3.22** Delirium is a severe state of confusion which usually has a short duration. It has the appearance of a mental illness but is typically the result of a physical illness. Consequently, the cause of an episode of delirium needs to be considered when determining the appropriateness of applying the Law. If the cause is physical in nature, the Capacity Law is likely to be the most appropriate means of effecting an intervention with a patient presenting with the symptoms of delirium.

Self-harm

- 3.23** Self-harm is not a mental illness in of itself but may be related to an underlying mental illness. Equally there will be situations where self-harm may not be related to such an underlying mental illness. Therefore it should not be assumed that a person who engages in self-harming behaviours is necessarily mentally unwell or in need of detention under the Law or treatment for a mental illness.
- 3.24** The factors contributing to a patient expressing feelings, intentions and behaviours relating to wishing to harm themselves are complex and varied.
- 3.25** In assessing the needs of a patient who presents with self-harming behaviour, the clinicians/professionals involved in the assessment will need to consider and balance a range of interrelated factors. Of crucial importance is the need to understand the patient's decision-making ability in relation to the behaviours and their current mental state.
- 3.26** There will be occasions when such a patient refuses interventions and offers of support. On these occasions, use of compulsory powers to detain the person to an Approved Establishment may be considered. However, such powers can only be used if the patient meets the criteria for detention. If the patient does not meet the criteria and has the capacity to make a decision in relation to refusing an intervention or service, the option of detaining the patient will not exist. It will be on these occasions that professional and personal anxiety relating to a patient's safety will be at its height. Consequently, the need to manage such anxieties in such circumstances will be critical and will need to be considered alongside the need to manage risk.
- 3.27** There will be occasions when a patient may meet the criteria for detention but professional opinion is that this is not the appropriate outcome given the considerations relating to the Guiding Principles (Chapter 1).

- 3.28** In the circumstances described in 3.26 and 3.27, an urgent risk management strategy meeting will need to be convened at the earliest opportunity in line with local policy.

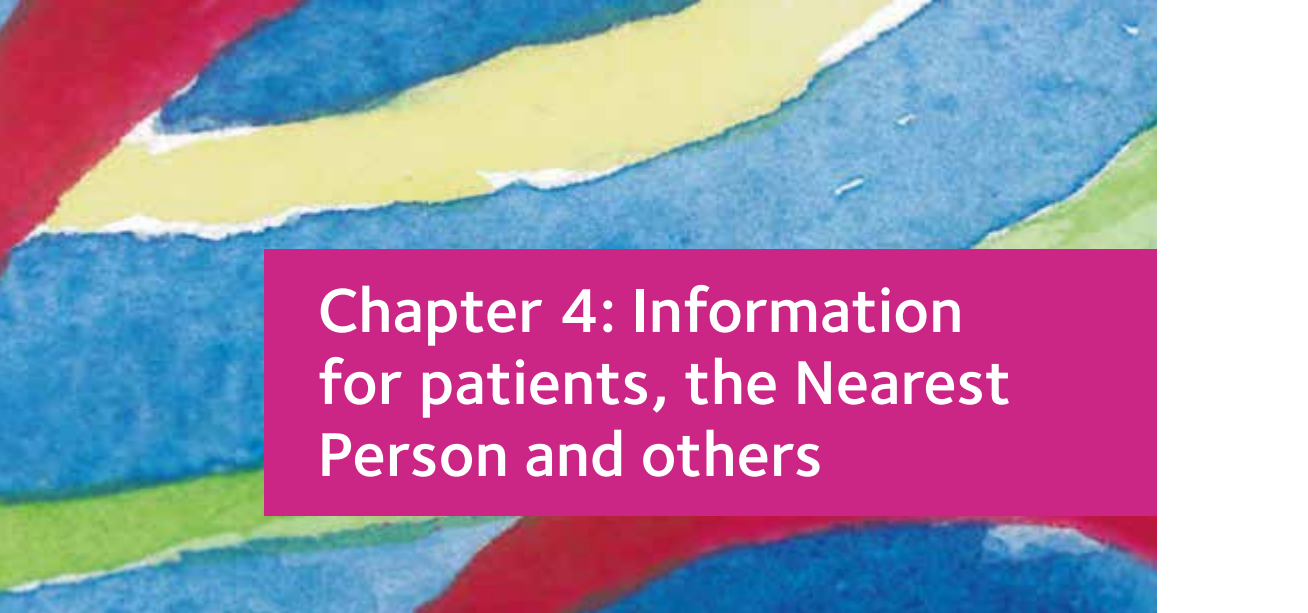
Suicidal ideation and intent

- 3.29** The factors contributing to a patient expressing feelings and intentions relating to suicide are complex and varied.
- 3.30** In assessing the needs of a patient who presents with suicidal behaviour, the clinicians/professionals involved in the assessment will need to consider and balance a range of interrelated factors. Of crucial importance is the need to understand the patient's decision-making ability in relation to the behaviours and their current mental state.
- 3.31** There will be occasions when such a patient refuses interventions and offers of support. On these occasions, use of compulsory powers to detain the person to an Approved Establishment may be considered. However, such powers can only be used if the patient meets the criteria for detention. If the patient does not meet the criteria and has the capacity to make a decision in relation to refusing an intervention or service, the option of detaining the patient will not exist. It will be on these occasions that professional and personal anxiety relating to a patient's safety will be at its height.
- 3.32** There will be occasions when a patient may meet the criteria for detention but professional opinion is that this is not the appropriate outcome given the considerations relating to the Guiding Principles (Chapter 1). However, this will need to be balanced against the need to uphold a patient's Article 1 (of the ECHR) right to life and the patient's general right to assessment and treatment of mental illness. How these competing factors are balanced is likely to be influenced by the degree and immediacy of risk and by the resources available in order to adequately reduce this risk given the availability of resources at the time of the assessment.
- 3.33** In the circumstances described in 3.31 and 3.32, an urgent risk management strategy meeting will need to be convened at the earliest opportunity in line with local policy.

Section 2: Protecting the rights and autonomy of patients

Why read this section?

The need to uphold the rights of patients, particularly those who are detained under the Law is paramount. This group of chapters detail the role and function of nearest persons, the considerations which must be made in relation to the sharing of confidential information and the role and function of Independent mental health advocates (IMHAs). These chapters provide guidance in respect of people who can represent or may have an interest in a patient's care and treatment. They provide guidance on the role and function of the Tribunal including the duty to inform patients and their nearest person about their rights of appeal to a Tribunal.



Chapter 4: Information for patients, the Nearest Person and others

Chapter 4

Communication with patients.....	26
Information for detained patients.....	27
Information about consent to treatment.....	28
Information about seeking a review of detention.....	29
Keeping patients informed of their rights.....	29
Information for Nearest Persons, carers and others.....	30

4

Chapter 4: Information for patients, the Nearest Person and others

- 4.1** This Chapter gives guidance on the information that must be given to patients, and their Nearest Person. It also gives guidance on communication with patients, their families and carers, and other relevant people.

Communication with patients

- 4.2** Effective communication is essential in ensuring appropriate care and respect for patients' rights. It is important that the language used is clear and unambiguous and that people giving information check that the information that has been communicated has been understood.
- 4.3** Everything possible should be done to overcome barriers to effective communication, which may be caused by any of a number of reasons. For example, a patient's first language may not be English. Patients may have difficulty in understanding technical terms and jargon or in maintaining attention for extended periods. They may have a hearing or visual impairment, have difficulty in reading or writing, or have a learning disability. A patient's cultural background may also be different from that of the person speaking to them. Children and young people will need to have information explained in a way they can understand and in a format that is appropriate to their age.
- 4.4** Where an interpreter is needed, every effort should be made to identify an interpreter who is appropriate to the patient, given the patient's gender, religion or belief, dialect, cultural background and age. A patient's relatives and friends as intermediaries or interpreters should not be used unless there are exceptional circumstances, which should be recorded. Interpreters (both professional and non-professional), must respect the confidentiality of any personal information they learn about the patient through their involvement. In situations where the services of an interpreter have been declined by the patient and they wish no communication support, this must be formally recorded.
- 4.5** A patient may choose not to accept the services of a professional interpreter and may request friends or family for this role. In such circumstances this must be recorded on the designated form. In no circumstances should a person under 16 years of age be used for this role.

- 4.6** Wherever possible, patients should be engaged in the processes of reaching decisions which affect their care and treatment under the Law. Consultation with patients involves supporting them to understand the information relevant to decisions, their own role and the roles of others who are involved in making decisions. Ideally decisions should be agreed with the patient. Where a decision is made that is contrary to the patient's wishes, that decision and the justification for it should be explained to the patient using a form of communication that the patient understands.
- 4.7** Written information must be made available to patients and families/ carers in a format and language which they can understand.

Information for detained patients

- 4.8** The Law requires Approved Establishment managers to take steps to ensure that patients who are detained in hospital under the Law understand information about how the Law applies to them. This must be done as soon as practicable after the start of the patient's detention. A combination of written and verbal communication should be utilised, provided in a language or format which the patient understands.
- 4.9** Patients should be given all relevant information pertaining to:

- How to make a complaint
- How to access support from an IMHA
- How to access legal representation
- The role of adult safeguarding/child protection and how to access these teams.

This information should be readily available to them throughout their detention.

- 4.10** Patients must be informed:

- of the provisions of the Law under which they are detained and the effect of those provisions.
- of the rights of their Nearest Person to discharge them (and what can happen if their RMO does not agree with that decision).
- (where appropriate) of the effect of a leave of absence (Article 24 Leave), including the conditions which they are required to keep and the circumstances in which their RMO may recall them to hospital, and
- of their right to request the support of an IMHA and the means of making such a request.

As part of this, they should be told:

- the reasons for their detention.
- the maximum length of the current period of detention.
- that their detention may be ended at any time if it is no longer required/the criteria for it are no longer met.
- that they will not necessarily be discharged automatically when the current period of detention ends.
- that their detention will not automatically be renewed or extended when the current period of detention ends.

That the patient has been informed of the above must be recorded in the patient's electronic record.

4.11 Patients should be told the legal and factual grounds for their detention. For the patient to be able to adequately and effectively challenge the grounds for their detention, should they wish, they should be given the full facts rather than simply the broad reasons. This should be done promptly and clearly.

4.12 A copy of the documentation pertaining to the detention should be made available to the patient unless the RMO is of the opinion, (based on the advice of those that made medical recommendations or the application), that the information disclosed would adversely affect the health or wellbeing of the patient or others. It may be necessary to remove any information relating to third parties. However, the patient ultimately has the right to have sight of information pertaining to their detention. In the event that information is withheld due to high levels of risk, it must be disclosed to the patient once the risk has sufficiently reduced.

4.13 Where there is a change in the Article of the Law under which the patient is being detained, they must be provided with information relating to the change.

Information about consent to treatment

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

- The circumstances (if any) in which they can be treated without their consent and the circumstances in which they have the right to refuse treatment.
- The role of the SOAD and the circumstances in which one might become involved.

Information about seeking a review of detention

4.15 Patients must be informed of:

- The right of the RMO to discharge them.
- Their rights to apply to the Tribunal.
- The role of the Tribunal.
- How to apply to a Tribunal.

4.16 Patients must also be informed of:

- How to contact a suitably qualified legal representative (and receive assistance to do so if required).
- That legal aid might be available.
- How to contact and access the services of an IMHA.

Keeping patients informed of their rights

4.17 Those with responsibility for patient care must ensure that patients are regularly reminded of their rights whilst the patient is either detained in hospital or subject to extended or indefinite Article 24 Leave. It may be necessary to repeat the same information on different occasions or in different formats and to check that the patient has fully understood it. Information given to a patient who is experiencing mental distress may need to be repeated when their condition has improved or when their capacity to understand information has increased.

4.18 It is particularly important that patients who are granted extended or indefinite Article 24 Leave and who may not have immediate access to people who could assist in making an application to a Tribunal are informed of their right to do so. Such patients must be provided with a plan upon leaving the Approved Establishment which details their rights and responsibilities. They will also have a Care Coordinator whose role will include ensuring that the patient is aware of their right to apply for discharge.

Information for Nearest Persons, carers and others


- 4**
- 4.19** The Law requires RMO's to take all practicable steps in order to give the patient's Nearest Person a copy of any information given to the patient in writing, unless the patient requests otherwise. The information should be given to the Nearest Person when the information is given to the patient, or within a reasonable time afterwards. In particular, the Nearest Person must receive information pertaining to any intended care or treatment in respect of a patient. This information should be provided as soon as is reasonably practicable. The responsibilities of the RMO relating to communication may be delegated in this instance but the RMO retains the responsibility to ensure that such communications have taken place.
- 4.20** The Nearest Person is entitled to make representations to the RMO in respect of any such care or treatment. Specifically this means that the Nearest Person has the right to speak to the patient's RMO (or the doctor acting on behalf of the RMO in the RMO's absence), and to request that a specific type of treatment or clinical intervention is or is not utilised in respect of the patient. Whilst the RMO need not adhere to the stated wishes of a Nearest Person, the RMO must have due regard to any such representation and should record any disagreement.
- 4.21** The Nearest Person must receive information pertaining to the renewal of a treatment authorisation; Article 24 Leave and any associated conditions; a plan of treatment where either consent or a second medical opinion is required; any changes associated with each of these measures.
- 4.22** It is acknowledged that there will be occasions when a patient has the capacity to refuse for information to be shared with Nearest Persons or others. In the event that such consent is refused, communication with Nearest Persons or others in respect of this should be undertaken with the utmost of sensitivity. It must be explained that the right of the patient to determine whether or when to share information must be respected. All such discussions must be recorded in the patient's notes. It is important to recognise that consent is time and decision specific.
- 4.23** Where a patient lacks the capacity to determine whether to permit the sharing of information, due regard should be given to their right of self-determination whilst balancing this with the need to openly and honestly share relevant information. Where necessary, decisions pertaining to the sharing of information should be undertaken according to the principles of the Capacity Law.

4.24 Patients may want to nominate one or more people who they would wish to be involved in, or notified of, decisions relating to their care and treatment. Patients may nominate an IMHA, another independent advocate, or a legal professional. They may also nominate a carer or other informal supporter or advocate. The involvement of such carers can have significant benefits for the care and treatment of the patient. People who know the patient well can provide knowledge of the patient and perspectives that come from long-standing and intimate involvement with the patient prior to (and during), their involvement with mental health services. They can provide practical assistance in helping the patient to articulate information and views and may have knowledge of advance decisions or statements made by the patient.

4.25 Professionals will generally agree to a patient's request to involve carers, relatives, friends or other informal supporters or advocates. They should tell the patient whenever such a request will not be, or has not been, granted. Where a patient's request is refused, this must be recorded in the patient's notes, giving reasons for the refusal. It may not always be appropriate to involve another person as requested by the patient, for example where:

- contacting and involving the person would result in a delay in making the decision in question and such a delay would not be in the patient's interests.
- the involvement of the person is contrary to the interests of the patient such as in the event that there are specific safeguarding concerns.
- that person has requested that they should not be involved.

4.26 Professionals must take steps to find out whether patients who lack capacity to make particular decisions for themselves have an Attorney or Delegate with authority to make the decision on their behalf. Where there is such a person, they act as though they are the patient, and must be informed in the same way as the patient themselves about matters within the scope of their authority.



Chapter 5: Confidentiality and information sharing

Chapter 5

Confidentiality – a brief summary	33
Disclosure of confidential patient information for the purposes of the Law.....	34
Limitations on sharing information with carers	36
Sharing information to manage risk.....	36
Recording disclosure without consent.....	37

Chapter 5: Confidentiality and information sharing

- 5.1** This Chapter deals with issues about confidentiality and information sharing which arise in connection with the Law.
- 5.2** The rules and principles in respect of confidentiality are the same for patients subject to the Law as they are for any other patients. Under the Law, there are some situations where confidential information about a patient is legally authorised to be shared, even if the patient does not consent. Guidance is given on the sharing of information by professionals and agencies to manage serious risks which certain patients pose to others.

Confidentiality – a brief summary

- 5.3** There will be specific considerations for healthcare professionals to whom the rules and principles of confidentiality apply. A duty arises when one person discloses information to another in circumstances where it is reasonable to expect that the information will be held in confidence. Certain situations, such as discussions with a health professional or social worker, are generally presumed to be confidential.
- 5.4** There are circumstances in which it is both justifiable and important to share otherwise confidential patient information with people outside the immediate team treating a patient. Before considering such disclosure of confidential patient information, the individual's consent will usually be sought. However, there will sometimes be situations where this is not safe, practicable or appropriate. In such circumstances, the decision not to request consent must be documented.
- 5.5** If a patient lacks capacity to consent to the disclosure, it may be acceptable and appropriate to disclose the information where there is significant risk of harm to the patient or others. Caldicott principles and the Data Protection (Jersey) Law 2018 must be used. The patient may have a legal decision-maker under the Capacity Law who is authorised to access and share the patient's information. Any decision should take into account the patient's previously expressed wishes and views. Where appropriate this should also include a discussion with the patient's Nearest Person.

Otherwise, confidential patient information should be disclosed outside the team only:

- with the patient's consent (where the patient has capacity to consent).
- if there is a specific legal obligation or authority to do so, or
- where there is an overriding public interest in disclosing the information. The 'public interest' is not the same as what might be of interest to the public.

Where confidential patient information is involved, public interest justifications for overriding confidentiality could include (but are not limited to) protecting other people from serious harm and preventing serious crime.

5.6 A person's right to have their privacy respected is protected by Article 8 of the European Convention on Human Rights (ECHR). The disclosure of confidential information may be a breach of that right unless it is a necessary and proportionate response to the situation.

5.7 A range of agencies may be involved in the provision of services to patients who are subject to compulsory measures under the Law. Patients must be consulted about what information it may be helpful to share with these services and when. Professionals should be clear about how the sharing of such information could benefit the patient or help to prevent serious harm to others and whether there are any potential negative consequences. IMHA's and advice services can support patients in deciding what information should be shared.

5.8 The sharing of information with carers and relevant others who have an interest in the care and wellbeing of the patient can contribute to and support their care and treatment. Where patients have capacity to agree and are willing to do so, carers and other relevant people must be given information about the patient's progress to enable them to form and to offer views about the patient's care. The purpose in this is in order to provide effective care and support to the patient. A patient's agreement to such disclosure must be freely given.

Disclosure of confidential patient information for the purposes of the Law

5.9 The Law creates a number of situations where confidential information about patients is legally authorised to be disclosed, even if the patient does not consent.

These include:

- reports to the Tribunal when a patient's case is to be considered.
- reports to the court on restricted patients.
- reports to the Minister.

5.10 The Law also gives certain people and bodies – including SOADs and (in certain circumstances) IMHAs – the right to access records relating to a patient's current care and treatment.

5.11 In addition, where the Law allows steps to be taken in relation to patients without their consent, confidential patient information may be disclosed only to the extent that it is necessary to take those steps. For example, confidential patient information may be shared to the extent that it is necessary for:

- medical treatment which may be given without a patient's consent under the Law.
- safely and securely transporting a patient to hospital (or anywhere else) under the Law.
- finding and returning a patient who has absconded from legal custody or who is absent without leave, or
- transferring responsibility for a patient who is subject to the Law from one establishment or jurisdiction to another (e.g. where a detained patient is to be transferred from one hospital to another, or where responsibility for a patient is to be transferred between Jersey and another jurisdiction).

5.12 Even though information may be disclosed in these cases, it is still necessary for people proposing to disclose the information to be confident that:

- it is necessary in the circumstances,
- that the aim of disclosure cannot reasonably be achieved without it,
- any breach of the patient's confidentiality is a proportionate response given the purpose for which the disclosure is being considered.

Care must also always be taken to ensure that any information disclosed is factual and accurate.

Limitations on sharing information with carers

- 5**
- 5.13** Simply asking for information from carers, relatives, friends or other people about a patient without that patient's consent need not involve any breach of confidentiality, provided the person requesting the information does not reveal any personal confidential information about the patient which the carer, relative, friend or other person being asked would not legitimately know.
- 5.14** Apart from information which must be given to Nearest Persons, the Law does not create any exceptions to the rules and principles about disclosing confidential patient information to carers, relatives or friends.
- 5.15** In order for carers to be provided with information about a patient's particular diagnosis or to be given any other confidential personal information about the patient, either the patient must consent or there must be another basis upon which to disclose the information in accordance with the Law. All carers should always be offered information which may support them to understand the nature of mental disorder generally, the ways it is treated and the operation of the Law.
- 5.16** Carers, relatives, friends and other people have a right to expect that any personal information about themselves will be treated as confidential.
- 5.17** Any information which is disclosed in relation to a patient should be shared with the patient unless there are overriding reasons justifying the withholding of such information. Such reasons are likely to pertain to significant risk. Any withholding of information must be within the parameters of the Law.

Sharing information to manage risk

- 5.18** Professionals and agencies may need to share information to manage any serious risks which certain patients pose to others. Such disclosure must be within the parameters of the Law.
- 5.19** Where the issue is the management of the risk of serious harm, the judgement required is normally a balance between:

- the public interest in disclosure, including the need to prevent harm to others,
- the rights of the individual concerned
- the public interest in maintaining trust in a confidential service.

5.20 Whether there is an overriding public interest in disclosing confidential patient information may vary according to the type of information being considered. Even in cases where there is no overriding public interest in disclosing detailed clinical information about a patient's state of health there may, nonetheless, be an overriding public interest in sharing more limited information about the patient's current, and past status under the Law. Justification underpinning such sharing of information is likely to relate to the need to ensure properly informed risk management by the relevant authorities, families and carers.

Recording disclosure without consent

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

Chapter 6: Role and function of Nearest Persons and nominated persons

Chapter 6

Role of Nearest Person	39
Appointment of Nominated Representative	40
The Nominated Representative as Nearest Person.....	40
Revocation, variation and cessation of appointment of Nominated Representative	40
Patients who do not have a Nominated Representative.....	41
Identification of Nearest Person.....	41
People who do not have a Nearest Person.....	41
“Ordinarily resident” and “not ordinarily resident”	42
“Cared for”	42
Where there is no Nominated Representative or Nearest Person.....	43
Displacement of Nominated Representatives and Nearest Persons and appointment of acting Nearest Persons by a court.....	44
Decisions in respect of involving a Nearest Person	47

Chapter 6: Role and function of Nearest Persons and nominated persons

6.1 This Chapter gives guidance on the appointment of, and revocation and cessation of Nominated Representatives, their role as Nearest Persons and the identification, appointment and displacement of Nearest Persons under the Law. It also gives guidance on the role and powers of Nominated Representatives and Nearest Persons.

Role of Nearest Person

6.2 The Nearest Person has a number of functions under the Law which are detailed below:

- can request the RMO to exercise the power to discharge the patient
- must be informed before the patient is granted leave of absence and of any conditions attached to such leave of absence
- must be informed as soon as practicable when a patient has been transferred between Approved Establishments
- must be informed of the provision of the Law under which the patient is held, the effect of that provision and what rights the patient has to make an appeal to the Tribunal
- must be informed of his own right to make an appeal to the Tribunal
- must be informed of the effects of the provisions of the Law regarding patients given extended or indefinite leave of absence and what rights the patient has to make an appeal to the Tribunal
- must be informed in advance of when the patient will be discharged
- must be informed of any proposal to make an application under Article 21 or 22
- must be informed of and be permitted to attend any Tribunal hearing regarding the patient
- must be given written details of treatment intended to be provided
- must be informed of and be permitted to attend any meetings regarding any proposed treatment for the patient

- has the function of being involved in all decisions in respect of the patient's treatment
- must be informed of the making of a hospital treatment order, and
- must be informed of the making of a restriction order.

6

Appointment of Nominated Representative

- 6.3** Article 10(1) of the Law allows an individual aged 18 years or over to appoint a person to act as their Nominated Representative.
- 6.4** Under Article 10(2) of the Law, an individual who is:
- aged under 18 years, or
 - aged 18 years or over but does not have the capacity to nominate a representative,
- may have someone appointed by the Minister.
- 6.5** An appointment of a Nominated Representative is made in writing on the prescribed form by the individual. The Nominated Representative must consent using the relevant form or otherwise in writing before they can carry out their duties under the Law.
- 6.6** An individual may appoint more than one person to act as their Nominated Representative. If they do so, they must state the priority in which they wish the Nominated Representatives to act under this Law.

The Nominated Representative as Nearest Person

- 6.7** A person who is appointed as a Nominated Representative in respect of a patient will be deemed under Article 10 to be that patient's Nearest Person for the purposes of this Law, having the rights and carrying out the functions of a Nearest Person with fairness, impartiality and independence in a manner that is in the best interests of the patient.

Revocation, variation and cessation of appointment of Nominated Representative

- 6.8** An individual or the Minister may revoke or vary the terms and conditions of the appointment made by giving further written notice on the prescribed form. Article 10(5) lists the situations in which the appointment of a Nominated Representative ceases, including the written withdrawal of consent by the Nominated Representative and the appointment by court of an acting Nearest Person.

Patients who do not have a Nominated Representative

- 6.9** Where a representative has not been nominated under Article 10, the Nearest Person of a patient should be ascertained by reference to Article 8.

Identification of Nearest Person

- 6.10** Articles 8 and 9 define “nearest relative” for the purposes of the Law. The Nearest Person is defined in Article 1(1), read with Part 2 of the Law. It is important to remember that the Nearest Person may not be the same person as the patient’s next of kin. The identity of the Nearest Person may also change with the passage of time (e.g. if the patient enters into a marriage or a civil partnership, or ordinarily resides with the relative in question).
- 6.11** It is also important to note in relation to patients who are children or young people: where a patient is under the care of the Minister under a care order made under the Children Law, the Department shall be deemed to be the Nearest Person of a patient in preference to any other person except the patient’s husband or wife; and where a guardian has been appointed for a patient, or a residence order made under the Children Law is in force in respect of a patient, the guardian or person named in the residence order shall be deemed to be the Nearest Person.

People who do not have a Nearest Person

- 6.12** Persons who:

- are remanded on bail under Article 61;
- are remanded to an Approved Establishment under Articles 62 or 63; or
- are subject to Interim Hospital Treatment authorisations under Article 64;

do not have Nearest Persons as they are not “patients” for the purposes of the Law.

However, persons who are subject to a Hospital Treatment authorisation (Article 65) or a Guardianship Order (Article 66), are deemed to be “patients” and therefore do have a Nearest Person.

“Ordinarily resident” and “not ordinarily resident”

6.13 Article 8(2) refers to a person with whom a patient ordinarily resides (or resided for the time when not an in-patient at a hospital or Approved Establishment) and Article 8(6) (a) refers to whether a person can be the Nearest Person of a patient depending upon where the person is ordinarily resident.

6.14 A person can be a Nearest Person of a patient if both the patient and that person are ordinarily resident in Jersey. Relatives who are not ordinarily resident in Jersey cannot be identified as the patient's Nearest Person but may be consulted as part of the assessment and care planning processes if this is appropriate and in line with the wishes of the patient. In the event that a patient wishes to appoint a person to act as Nearest Person, there is no requirement in the Law for the appointed person to be ordinarily resident in Jersey.

6.15 “Ordinarily resident” is not defined under the Law.

When deciding if a person is “ordinarily resident” with a person or in a particular place, the following points should be considered:

(a) ordinary residence:

- is a question of fact in each case
- is not equivalent to physical presence
- can exist without continuous presence
- must be adopted voluntarily and for settled purposes
- in one place can be lost immediately but acquisition of a new ordinary residence requires an appreciable length of time, which depends upon the nature and quality of connection with the new place
- ordinary residence is not broken by temporary or occasional absences of long or short duration.

(b) in order to establish ordinary residence over a period of time, a person must spend more than a token part of that period in the place in question; and

(c) it is possible to be ordinarily resident in more than one place at the same time.

“Cared for”

6.16 Article 8 (2) refers to a situation where a patient is being cared for by a relative.

6.17 When deciding if a patient is being “cared for” by a relative, the following points should be considered:

- the care provided must be more than minimal
- the care provided need not have been provided over the long term
- unlike the question of residence, the person need not be “ordinarily” cared for by the relative
- a patient may be “cared for” by a relative without sharing a residence and,
- the duration, continuity and quality of the care provided and the intention of the patient are relevant factors.

6.18 If a patient is cared for by more than one relative, or lives with one relative and is cared for by another:

- the relative who comes first in the Article 8 (3) list
or
- if the relatives are in the same category in that list, the elder or eldest relative; becomes the Nearest Person.

6.19 A Nearest Person is not obliged to act as such and can confirm in writing to the Minister that they are unable or unwilling to act as such. They cannot authorise another person to perform the functions of the Nearest Person on their behalf.

Where there is no Nominated Representative or Nearest Person

6.20 Where an AO discovers, when assessing a patient for possible detention under the Law (or at any other time) that the patient appears to have no Nominated Representative or Nearest Person, the AO should advise the patient:

- of their right to appoint a Nominated Representative under Article 10 (1); and
- of the right of any relative of theirs, any other person they were living with, or the AO to apply to court for the appointment of an acting Nearest Person under Article 11.

Displacement of Nominated Representatives and Nearest Persons and appointment of acting Nearest Persons by a court

Grounds for appointment and displacement

6.21 Under Article 11, the court may appoint an acting Nearest Person where that person is, in the opinion of the court, an appropriate person to act as the patient's Nearest Person and is willing to do so.

6.22 An acting Nearest Person may be appointed by the court on the grounds that:

(a) a Nominated Representative has not been appointed:

- the patient has no Nearest Person within the meaning of this Law, or that it is not reasonably practicable to ascertain whether they have such a relative, or who that relative is
or
- the Nearest Person is incapable of acting as such because of mental disorder or other illness
or
- the Nearest Person is otherwise not a suitable person to act as such

(b) a Nominated Representative has been appointed but

- the Nominated Representative is incapable of acting as such because of mental disorder or other illness, or
- the Nominated Representative is otherwise not a suitable person to act as such.

6.23 The effect of a court order appointing an acting Nearest Person is to revoke the appointment of any Nominated Representative who has been appointed as Nominated Representative by the patient. As a Nominated Representative is also deemed to be a patient's Nearest Person, an acting Nearest Person replaces any Nearest Person found by reference to Article 8.

Making an application to the court

6.24 An application to appoint an acting Nearest Person may be made by any of the following people:

- any relative of the patient;
- any other person with whom the patient is residing (or was residing prior to admission); or
- an AO.

Applications to courts by AOs

6.25 AOs will need to consider making an application for the appointment of an acting Nearest Person if:

- the patient has not appointed a Nominated Representative and there is no identifiable Nearest Person;
- the patient's Nominated Representative or, if no representative has been nominated by the patient, their Nearest Person is incapable of acting as such; or
- they have good reasons to think that a patient's Nominated Representative or Nearest Person is unsuitable to act as such. Examples of such reasons might include concerns relating to risk in the relationship between the Nearest Person and the patient; concerns relating to the ability of the Nearest Person to fulfil the role on account of their own needs and vulnerabilities or unwillingness of the Nearest Person to engage constructively in discussions about the patient's care and treatment.

6.26 It is entirely a matter for the court to decide what constitutes an appropriate person to be the patient's Nearest Person. Factors which an AO might wish to consider when deciding whether to make an application to the court to appoint an acting Nearest Person on the grounds they think a Nominated Representative or Nearest Person are unsuitable, and when providing evidence in connection with an application, may include:

- any reason to think that the patient has suffered, or is suspected to have suffered, abuse at the hands of the Nearest Person (or someone with whom the Nearest Person is in a relationship), or is at risk of suffering such abuse
- any evidence that the patient is afraid of the Nearest Person or seriously distressed by the possibility of the Nearest Person being involved in their life or their care, and
- a situation where the patient and the Nearest Person are unknown to each other, there is only a distant relationship between them, or their relationship with the Nearest Person has broken down irretrievably.

This is not an exhaustive list.

6.27 When applying to appoint an acting Nearest Person, AOs should know in advance who they are nominating. Wherever practicable, they should first consult the patient about the patient's own preferences and any concerns they have about the person the AO proposes to nominate. AOs should also seek the agreement of the proposed nominee prior to an application being made, as the court may only appoint a person who is willing to act as the acting Nearest Person.

- 6.28 In all cases, the decision to make an application lies with the AO.
- 6.29 The Department should ensure AOs have access to the necessary legal advice and support.

Making an application

- 6.30 A person making an application to a court will need to provide the court with the facts that will help it make a decision on the application. Exactly what will be required will depend on the type of application and the specific circumstances of the case.
- 6.31 If the patient has any concerns that any information given to the court on their views of the suitability of their Nearest Person may have implications for their own safety, an application can be made to the court seeking its permission not to make the current Nominated Representative or Nearest Person party to the proceedings.
- 6.32 Ward managers should provide support to detained patients to enable them to attend the court, if they wish, subject to the patient being granted leave under Article 24 for this purpose.
- 6.33 If the court finds that the person proposed to be appointed as acting Nearest Person is an appropriate person to do so, and that person is willing to act as Nearest Person, then the court may decide to appoint them.
- 6.34 An appointment as an acting Nearest Person can take place for a set period or until the court makes a further order.

Discharge & variation of orders by courts

- 6.35 Where a court has appointed an acting Nearest Person –

- the person appointed; or
- the person who was the Nearest Person before the acting Nearest Person was appointed;

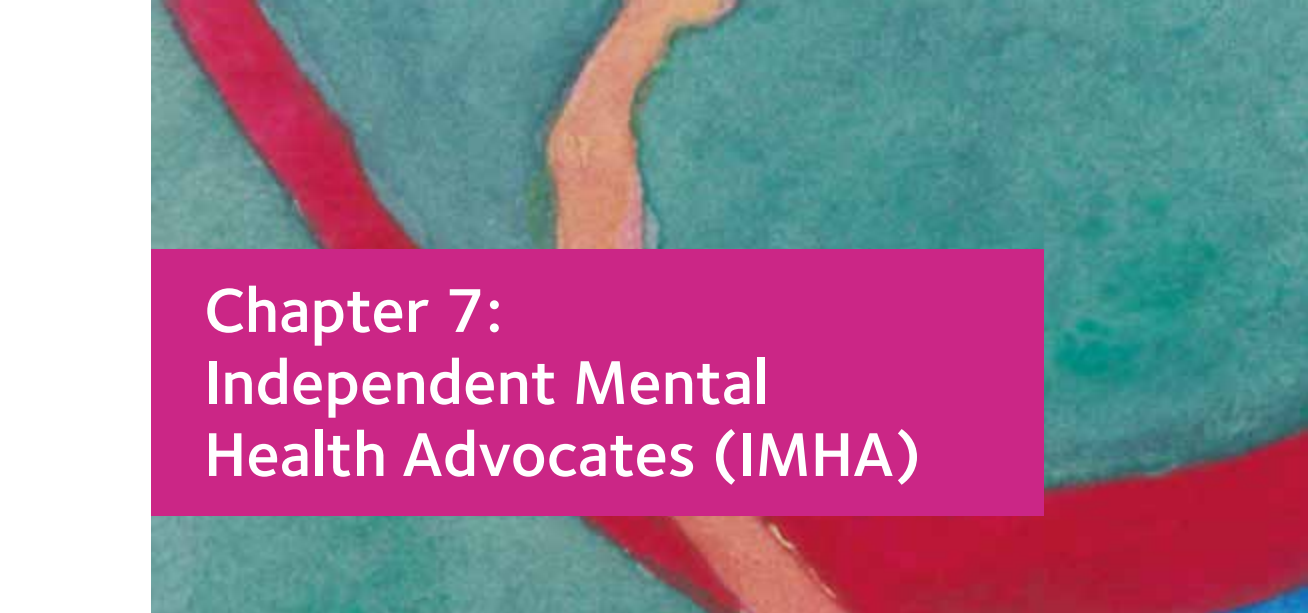
may apply for the appointment to be discharged.

- 6.36 The person appointed as acting Nearest Person or the AO can also apply for the substitution of another person to undertake the role of acting Nearest Person, in place of the person originally appointed by the court.
- 6.37 Where an acting Nearest Person dies, the functions of Nearest Person cannot be exercised until such time as an application for discharge or substitution is made.

- 6.38** Where the court has made an appointment for a set period, the appointment is only valid for that period.
- 6.39** If the court does not set a period for the appointment and the patient:
- (a) was liable to be detained under an order or direction under Part 3 or 9 (other than under Article 61, 62, 63 or 64) on the date of the order or becomes so liable within 3 months of that date, the appointment shall cease to have effect when the patient ceases to be liable to detention, or
 - (b) was not liable to be detained on the date of order and does not become so liable within 3 months of that date, the appointment shall cease to have effect at the expiration of the 3 month period.

Decisions in respect of involving a Nearest Person

- 6.40** The Law ascribes specific rights to a Nearest Person. However, a patient also has the right to respect for private and family life. A patient may request that their Nearest Person's rights are not upheld. This poses a dilemma for professionals. The conflict between the rights of the patient and their Nearest Person should be explained to the patient where possible and appropriate. The patient should be informed/ reminded of their right to nominate an alternative Nearest Person and of the process associated with this.
- 6.41** If a decision is taken to withhold information from a Nearest Person, the patient's RMO is required to inform the Nearest Person of the reasons for this, in writing where practicable.
- 6.42** Information may only be withheld from the Nearest Person if one or more particular conditions are satisfied (Article 13.3). These are:
- that the patient has the capacity to decide that specific or general information be withheld
 - that the patient lacks such capacity but that disclosure is not in the patient's best interests
 - that disclosure is likely to cause serious harm to the patient or others.



Chapter 7: Independent Mental Health Advocates (IMHA)

Chapter 7

Purpose of IMHA services	49
Patients who are eligible for IMHA services (qualifying patients).....	50
The role of IMHAs	50
Duty to inform patients about the availability of IMHA services	51
Seeking support from an IMHA	52
IMHAs' access to patients and professionals.....	52
IMHAs' access to patients' records.....	53

Chapter 7: Independent Mental Health Advocates (IMHA)

- 7.1** IMHAs provide an additional safeguard for patients who are subject to the Law. They support patients to exercise their rights and ensure they can participate in the decisions that are made about their care and treatment. They do not replace any other advocacy or support services and work in conjunction with other services. They support qualifying patients to obtain relevant information and to understand their position including their rights and aspects of their treatment.
- 7.2** It is generally accepted that there the ability of a patient to effectively express their own views, feelings, hopes and expectations is likely to significantly enhance the likelihood of the achievement of recovery. The role of the IMHA is a key component within this. Mental health professionals including clinicians and Approved Establishment managers have a role to play in ensuring that IMHAs feel welcome on a ward and in ensuring that rooms/appropriate space are made available for IMHAs and patients to meet without being overheard. Staff working with patients must ensure that essential information relating to well-being or risk is communicated to IMHAs (given the usual responsibilities relating to patient confidentiality), in order that IMHAs remain safe in their role. Consideration should be made of promoting the attendance of IMHAs at relevant meetings and such meetings should be arranged in order that IMHAs are able to attend where possible.
- 7.3** Whilst it is not permissible to provide information to IMHA's without the consent of the patient, patients who are eligible for the services of an IMHA should be actively encouraged by professionals supporting them, to consider making use of this service.

Purpose of IMHA services

- 7.4** IMHAs are specialist advocates who are trained specifically to work within the framework of the Law and enable patients to participate in decision-making. IMHAs should be independent of any person who has been professionally involved in the patient's treatment.

- 7.5** IMHA services do not replace any other advocacy and support services that are available to patients, such as Independent Capacity Advocates (ICAs), under the Capacity Law and are intended to operate in harmony with those services.
- 7.6** The same advocate may be qualified to act as an IMHA and an ICA though these are different roles. For detailed guidance on the functions of ICAs see the Capacity Law and its associated Code of Practice.

7 Patients who are eligible for IMHA services (qualifying patients)

- 7.7** Patients are eligible for support from an IMHA, irrespective of their age, if they are:

- detained under the Law
- liable to be detained under the Law, even if not actually detained, including those who are currently on Article 24 leave of absence from hospital or absent without leave, or those for whom an application or court order for admission has been completed.

- 7.8** For these purposes, detention does not include being detained:

- under the ‘holding powers’ in Article 15 and 17 or,
- in a place of safety under Article 35 or 36.

- 7.9** Other patients (‘informal patients’) are eligible if they are being considered for a treatment detailed in Part 6 of the Law.

The role of IMHAs

- 7.10** The support which IMHAs provide must include helping patients to obtain information about and understand the following:

- their rights under the Law
- the rights which other people have in relation to them under the Law
- the particular parts of the Law which apply to them (e.g. the basis on which they are detained) and which therefore make them eligible for advocacy
- any conditions or restrictions to which they are subject (e.g. as condition of leave of absence from hospital)

- any medical treatment that they are receiving or might be given
- the reasons for that treatment (or proposed treatment), and
- the legal authority for providing that treatment, and the safeguards and other requirements of the Law which would apply to that treatment
- the role, functions and powers of the patient's Nearest Person.

7.11 IMHAs have a role in supporting patients to exercise their rights, which can include representing them and speaking on their behalf, e.g. by accompanying them to review meetings. IMHAs support patients in a range of other ways to ensure they can participate in the decisions that are made about their care and treatment, including supporting them to make applications to the Tribunal.

7.12 The involvement of an IMHA does not affect a patient's right (nor the right of their Nearest Person) to seek advice from a lawyer. Nor does it affect any entitlement to legal aid. IMHAs may, if appropriate, support the patient to exercise their rights by assisting patients to access legal advice and supporting patients at Tribunal hearings.

Duty to inform patients about the availability of IMHA services

7.13 The Approved Establishment manager has a duty to take whatever steps are practicable to ensure that qualifying patients understand that support is available to them from IMHA services and how they can obtain that support. This information should be provided at the point that the patient becomes eligible. At such times it is also the responsibility of the manager to provide such information to the patient's Nearest Person unless the patient requests otherwise (and subject to the normal considerations about involving Nearest Persons).

7.14 If a patient lacks capacity to decide whether or not to obtain support from an IMHA, the manager should ask an IMHA to attend the patient so that the IMHA can explain what they can offer to the patient directly.

7.15 Any information about independent mental health advocacy services should make clear that the service is for patients and is not an advocacy service for Nearest Persons themselves.

Seeking support from an IMHA

7.16 A qualifying patient may request the support of an IMHA at any time after they become a qualifying patient. Patients have the right to access the independent mental health advocacy service itself, rather than the services of a particular IMHA, though where possible it would normally be good practice for the same IMHA to remain involved while the person remains subject to the Law.

7.17 IMHAs must also comply with any reasonable request to visit and interview a qualifying patient, if the request is made by the patient's Nearest Person, an AO or the patient's RMO.

7.18 Before requesting an IMHA to visit a patient, wherever practicable this should be discussed with the patient, and give the patient the opportunity to decide for themselves whether to request an IMHA's help.

7.19 Patients may refuse to be interviewed and do not have to accept support from an IMHA if they do not want it. Equally, a patient may choose to end the support they are receiving from an IMHA at any time.

IMHAs' access to patients and professionals

7.20 Patients should have access to a telephone on which they can contact the IMHA service and talk to them in private.

7.21 Clinicians, Approved Establishment managers (Approved Establishment managers for Guardianship patients) should ensure that IMHAs are able to:

- access wards and units on which patients are resident
- meet with the patients they are supporting in private, unless the patient objects or it is otherwise inappropriate (for example where the risk is too great)
- attend meetings between patients and the professionals involved in their care and treatment when asked to do so by patients
- interview any professional concerned with the patient's current treatment.

- 7.22** Professionals should uphold confidentiality when discussing a patient and their care or treatment with an IMHA even when the conversation is at the patient's request. IMHAs have a right of access to patients' records provided that the patient provides consent and has the capacity to provide such consent. It is important that any legal decisions regarding access to information made by an Attorney or Delegate are respected. Otherwise the same rules in respect of information sharing apply.

IMHAs' access to patients' records

- 7.23** Where the patient consents, IMHAs have a right to see any relevant clinical or other records relating to the patient's current detention or treatment or relating to any after-care services provided to the patient.
- 7.24** Where the patient does not have the capacity to consent to an IMHA having access to their records, the holder of the records must allow the IMHA access if they think that it is appropriate and that the records in question are relevant to the support to be provided by the IMHA.
- 7.25** When an IMHA seeks access to the records of a patient who does not have the capacity to consent, the person who holds the records should ask the IMHA to explain what information they think is relevant to the support they are providing to the patient and why they think it is appropriate for them to be able to see that information. Appropriateness in this instance should be understood as that which is in the best interests of the patient. Such decisions should be taken in accordance with the principles of best interests as defined in the Capacity Law and its associated Code of Practice.
- 7.26** Records must not be disclosed if that would conflict with a decision made on the patient's behalf by the patient's Attorney or Delegate, or by the court.
- 7.27** If the record holder thinks that disclosing the confidential patient information in the records to the IMHA would be in the patient's best interests, it is likely to be appropriate to allow the IMHA access to those records in all but the most exceptional cases.



Chapter 8: Privacy, safety and dignity

Chapter 8

Respect for privacy.....	55
Blanket restrictions.....	56
Blanket locked door policy.....	56
Private telephone calls and e-mail and internet access.....	57
Private property.....	59
Separate facilities for men and women.....	60
Separate facilities for other reasons.....	60
Personal and other searches.....	61
Conducting personal and other searches.....	61

Chapter 8: Privacy, safety and dignity

- 8.1** This Chapter deals with privacy, safety and dignity in hospitals where patients are detained under the Law, including access to telephones and other mobile computing devices, access to the internet, and the use of searches.
- 8.2** Privacy, safety and dignity are important constituents of a therapeutic environment and hospital staff should respect a patient's privacy as far as possible, while maintaining safety. Patients should have every opportunity to maintain contact with family and friends by telephone. Hospitals and other Approved Establishments should ensure they have policies for the use of mobile phones and computing devices.
- 8.3** Sleeping and bathroom areas should be segregated to protect the needs of patients of different genders and transgender patients. The Chapter also includes guidance on conducting personal and other searches, enhanced security, physical security and blanket locked door policy.

Respect for privacy

- 8.4** Article 8 of Convention requires public authorities to respect a person's right to private and family life. Article 8 of the ECHR has particular importance for people detained under the Law. Hospital staff should make conscious efforts to respect the privacy and dignity of patients as far as possible, while maintaining safety, including enabling a patient to wash and dress in private, and to send and receive mail, including in electronic formats, without restriction. Respecting patients' privacy encompasses the circumstances in which patients may meet or communicate with people of their choosing in private, including in their own rooms, and the protection of their private property.
- 8.5** It is acknowledged that where particular risks relating to the patient's own health or safety exist or where there are particular risks to others, an interference with a patient's Article 8 ECHR rights may be justified in order to uphold their Article 1 ECHR rights.

Blanket restrictions

- 8.6** In this Chapter, the term ‘blanket restrictions’ refers to rules or policies that restrict a patient’s liberty and other rights, which are routinely applied to all patients without individual risk assessments to justify their application. Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each patient should be considered and documented in the patient’s records.
- 8.7** Restrictions should only ever be imposed as a proportionate and measured response to an individually identified risk and for no other reason. Such restrictions should be applied for no longer than can be shown to be necessary.
- 8.8** Blanket restrictions include restrictions concerning: access to the internet, access to (or banning) mobile phones and chargers, incoming or outgoing mail, visiting hours, access to money or the ability to make personal purchases, or taking part in preferred activities.
- 8.9** No form of blanket restriction should be implemented unless expressly authorised by the Approved Establishment managers on the basis of the organisation’s policy and subject to local accountability and governance arrangements.

Blanket locked door policy

- 8.10** A blanket locked door policy which affects all patients in a hospital or on a ward could, depending on its implementation, amount to a restriction or a significant restriction on liberty.
- 8.11** It is unlikely that there will be a significant restriction on liberty if an informal patient, who has capacity to consent to being admitted and has done so, is informed of the locked door policy and consents to being informally admitted and remaining on the ward under these conditions. The patient should be told who they can speak to if they wish to leave and must be able to leave at any time, unless they are being detained using emergency holding powers.
- 8.12** It is to be acknowledged that a blanket locked door policy may be necessary in order to protect the safety and privacy of patients given the possibility of illegitimate entry to a hospital ward by others.
- 8.13** A patient’s Article 8 (ECHR) rights should be protected by ensuring a locked door policy only imposes proportionate restrictions on their contact with family and friends which can be justified as being in the interests of the health and safety of the patient or others. The impact of a locked door policy on each patient should be considered and documented in the patient’s records.

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

Private telephone calls and e-mail and internet access

- 8.15** Communication with family and friends is integral to a patient's care and hospitals should make every effort to support the patient in making and maintaining contact with family and friends by telephone, mobile, e-mail or social media.
- 8.16** Mobile phones and other electronic devices commonly have functions including cameras, video and voice recording capability. There is therefore the potential for patients and visitors to use such equipment in a way that interferes with the confidentiality, dignity and privacy of other patients, staff and visitors. Staff should be mindful of enabling patients and visitors to maintain communication and contact while protecting others against the misuse of such technology.
- 8.17** It may be appropriate for a corporate server to be utilised by patients wishing to access the internet in the interests of upholding the law and of maintaining the safety of others.
- 8.18** When patients are admitted, staff should assess the risk and appropriateness of patients having access to mobile phones and other electronic devices and this should be detailed in the patient's care plan. Particular consideration should be given to people who may have specific communication needs and how such needs might be met. Patients should be able to use such devices if deemed appropriate and safe for them to do so and access should only be limited or restricted in certain risk-assessed situations.
- 8.19** Approved Establishment managers should have a policy for the possession and use of mobile phones and other mobile devices (such as laptops and tablets). These should be proportionate to risk and not seek to impose blanket restrictions on patients.
- 8.20** When formulating a policy on the use of mobile phones and mobile devices, Approved Establishment managers should bear in mind the following points:

- Mobile phones and mobile computing devices provide a readily available means of communication with family and friends and are in widespread use. Most detained patients are therefore likely to have one. It is unlikely to be appropriate to impose a blanket restriction banning their use

- Different considerations will apply to different locations within the hospital. There may be valid reasons for banning or limiting the use of mobile phones or mobile computing devices in some parts of the premises to which detained patients have access or certain types of mobile phone or mobile computing device, e.g. because of the potential risk of interference with medical and other electronic equipment which could adversely affect the health of patients or because of the risk of intrusion into the privacy of other patients or others
- Each patient should expect a peaceful environment, and that constant interruptions from ringing telephones have a potentially anti-therapeutic effect
- It may be reasonable to require mobile phones and mobile computing devices to be switched off except where their use is permitted and to restrict their use to designated areas to which detained patients have access
- Many mobile phones and mobile computing devices have cameras and give access to the internet and can be used as sound recorders. This creates a potential for the violation of the privacy and dignity of other patients, staff and visitors to the ward and may constitute a security risk. It would therefore be appropriate to stipulate the circumstances in which photographs, videos and sound recordings can be taken, e.g. only with specific permission from hospital staff and the patients involved
- The difficulty in identifying when camera functions are being used may be an additional reason for restricting the areas in which mobile phones and computing devices may be used
- It is important to ensure that the hospital's policy on the use of mobile phones and mobile computing devices can be enforced effectively, e.g. it may be appropriate in certain circumstances to confiscate mobile phones or mobile computing devices from patients who consistently refuse to comply with the rules
- Any decision to prevent the use of cameras or to confiscate a mobile phone or mobile computing device should be fully documented and be subject to periodic review
- There should be rules on when staff and visitors can bring mobile phones and mobile computing devices into a secure setting
- The normal rules governing the use of the hospital's power supply to charge mobile phones or mobile computing devices may need to be varied for detained patients (given the restrictions with which such patients are faced)

- Staff should be fully informed of the hospital's policy, and steps should be taken to communicate it to all patients, carers, families and visitors, e.g. by displaying it clearly in each unit and providing it in a format and language that a patient can understand
- The policy will need to be reviewed regularly, and updated where necessary, in the light of experience. It is good practice to involve patients, former patients and their carers in drawing up the policy.

- 8.21** Managers should develop policies on access by patients to e-mail and internet facilities by means of the hospital's IT infrastructure. This guidance should cover the availability of such facilities and rules prohibiting access to illegal or what would otherwise be considered inappropriate material, e.g. pornography, gambling or websites promoting violence, abuse or hate. Additionally, the guidance should cover the appropriate use of social media such as Skype. A blanket restriction on access to the internet could breach Article 8 of the ECHR if it cannot be justified as necessary and proportionate.
- 8.22** Managers should also develop guidance on the use of social media. A blanket restriction on the use of social media could breach Article 8 of the ECHR if it cannot be justified as necessary and proportionate. Staff should remind patients of confidentiality requirements, and the implications of breaching patient and staff confidentiality, and encourage patients to consider what they post on social media. Where wards provide a telephone for the use of patients, Approved Establishment managers should ensure that patients are able use them without being overheard. Some patients may need support to make a phone call, but should still be given privacy during the call.
- 8.23** The principle that should underpin hospital or ward policies on all telephone use is that detained patients are not free to leave the premises but that their freedom to communicate with family and friends should be maintained as far as possible and restricted to the minimum extent necessary.

Private property

- 8.24** Hospitals should provide adequate storage in lockable facilities (which staff will be able to unlock if necessary) for clothing and other personal possessions which patients may keep with them on the ward and for the secure central storage of anything of value or items which may pose a risk to the patient or to others, e.g. razors. Information about arrangements for storage should be easily accessible to patients on the ward. Hospitals should compile an inventory of what has been allowed to be kept on the ward and what has been stored and give a copy to the patient. The inventory should be updated when necessary. Patients should always be able to access their private property on request if it is safe to do so.

Separate facilities for men and women

8.25 All sleeping and bathroom areas must be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided. Where possible provision should be made for women-only day rooms. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. Consideration should be given to the particular needs of transgender patients: where possible such patients should be asked their preference in respect of gendered accommodation.

8.26 A patient should not be admitted to mixed-gender accommodation. It may be acceptable, in a clinical emergency, to admit a patient temporarily to a single, en-suite room in the opposite-gender area of a ward. In such cases, a full risk-assessment should be carried out and the patient's safety, privacy and dignity maintained. Steps should be taken to rectify the situation as soon as possible.

Separate facilities for other reasons

8.27 Arrangements for the patient's accommodation should also consider the patient's history and personal circumstances, including:

- history and personal circumstances where known, including history of sexual or physical abuse and risks of trauma
- the particular needs of transgender patients
- cultural or religious preferences
- mothers and babies during and after pregnancy, or
- other health conditions (physical disabilities, learning disabilities or sensory impairments).

8.28 If, in an emergency, it is necessary to treat a patient in an environment that does not fully meet their needs, then senior management should be informed, steps should be taken to rectify the situation as soon as possible, and staff should protect the patient's privacy and dignity against intrusions – particularly in sleeping accommodation, toilets and bathrooms.

Personal and other searches

8.29 The Department will provide an operational procedure and guidelines in relation to the conducting of searches. Searches can be undertaken of patients, their belongings and surroundings and their visitors. When preparing the procedure and guidelines, consideration must be made of the position of informal patients.

8.30 The procedures and guidelines should be based on the following clear principles:

- the intention is to create and maintain a therapeutic environment in which treatment may take place and to ensure the security of the premises and the safety of patients, staff and the public
- searching should be proportionate to the identified risk and should involve the minimum possible intrusion into the individual's privacy, and
- all searches will be undertaken with due regard to and respect for the person's dignity and privacy.

8.31 The authority to conduct a search of a person or their property must constitute a legitimate interference with a patient's Article 8 ECHR rights and it is therefore crucial that hospital staff are aware of whether they have legal authority to carry out any such search. If there is doubt about this, legal guidance must be sought.

8.32 The policy may extend to the routine and random searching, without cause, of detained patients, if necessary without their consent, but only in exceptional circumstances. For example, such searches may be necessary if the patients detained in a particular unit tend to have dangerous or violent propensities which means they create a self-evident pressing need for additional security.

8.33 Patients, staff and visitors should be informed that there is a procedure on searching. The procedure associated with searches should be clearly displayed and communicated to patients and their visitors in a format and language they understand.

Conducting personal and other searches

8.34 Whilst it is acknowledged that the legal powers of staff to search patients have not been expressly laid down in legislation, searches are a component of safe clinical practice. The Minister has a specific duty to provide both a safe and therapeutic living environment for patients; a safe working environment for staff and to protect members of the public and visitors to Approved Establishments.

- 8.35** The consent of the person should always be sought before a personal search of them or a search of their possessions is attempted. If consent is given, the search should be carried out with regard to ensuring the maximum dignity and privacy of the person. Undertaking a personal search in a public area will only be justified in exceptional circumstances.
- 8.36** Consent obtained by means of a threat, intimidation or inducement is likely to render the search illegal.
- 8.37** A person being searched or whose possessions are the subject of a search should be kept informed of what is happening and why. If they do not understand or are not fluent in English, the services of an interpreter should be sought, if practicable. The specific needs of people with impaired hearing or a learning disability and those of children and young people must be considered.
- 8.38** A personal search should be carried out by a member of the same sex, unless necessity dictates otherwise. The search should be carried out in a way that maintains the person's privacy and dignity and respects issues of gender, culture and faith. It is always advisable to have another member of the hospital staff present during a search, especially if it is not possible to conduct a same-sex search.
- 8.39** A comprehensive record of every search, including the reasons for it and details of any consequent risk assessment, should be made.
- 8.40** Staff involved in undertaking searches should receive appropriate instruction and refresher training.
- 8.41** If a search is considered necessary, despite the patient's objections, the search should be carried out. If force has to be used, it should be the minimum necessary.
- 8.42** Where a patient physically resists being personally searched, physical intervention should normally only proceed on the basis of a multi-disciplinary assessment, unless it is urgently required. A post-incident review should follow every search undertaken where consent has been withheld.
- 8.43** Where a patient's belongings are removed during a search, the patient should be told why they have been removed, given a receipt for them, told where the items will be stored, and when they will be returned.
- 8.44** The exercise of powers of search should be audited regularly and the outcomes reported to the Approved Establishment managers.
- 8.45** Intimate searches may not be undertaken by community mental health staff members.



Chapter 9: Visiting patients in hospital

Chapter 9

People with a right to visit patients	64
Exclusion or restriction of visitors	65
Restriction or exclusion on clinical grounds	65
Restriction or exclusion on security grounds	66
Monitoring by Approved Establishment managers.....	66
Children and young people.....	66

Chapter 9: Visiting patients in hospital

9

- 9.1** This Chapter covers visiting patients in hospital and circumstances where it may be necessary to consider the exclusion of visitors. It includes particular considerations for child visitors and how far an individual should be placed from their family and/or local community.
- 9.2** All patients have a right to maintain contact with family and friends and to be visited, subject to carefully limited exceptions. The Law gives certain people the right to visit patients in private and arrangements must be in place to enable this to happen. Approved Establishment managers have the right, under certain circumstances to restrict or refuse visitors, or require them to leave.
- 9.3** All hospitals should have written policies and procedures concerning the arrangements for children and young people who visit patients and for visits to patients who are children or young people.
- 9.4** All patients have the right to maintain contact with, and be visited by, anyone they wish to see, subject to carefully limited exceptions. The value of visits in maintaining links with family and community networks is recognised as a key element in a patient's care, treatment and recovery. Article 8 of the Convention upholds the right to privacy and a family life. In particular, every effort should be made to support parents to support their children. Patients should be able to see all their visitors in private, including in their own bedroom if the patient wishes.
- 9.5** Visits should be encouraged and made as comfortable and easy as possible for the visitor and the patient. Reasonable and flexible visiting times, access to refreshments and pleasant surroundings will all contribute to a sense of respect for the patient's entitlement to be visited.

People with a right to visit patients

- 9.6** The Law gives certain people the right to visit patients in private if they wish. This includes Second Opinion Appointed Doctors (SOADs), independent doctors appointed by the Tribunal and Independent Mental Health Advocates (IMHAs). These people should be given access to all areas where the patient lives or has access.

- 9.7 Approved Establishment managers must ensure that such visits can take place in private, if that is what the person concerned wants.
- 9.8 If there are particular concerns for the security of the visitor, they should be discussed with the visitor with a view to agreeing suitable security arrangements. For the safety of both visitors and patients, visitors should only be in clinical areas under supervision.
- 9.9 Approved Establishment managers should also ensure that patients can communicate with their legal representatives in private, and should facilitate visits by those representatives when they request them.

Exclusion or restriction of visitors

- 9.10 There are circumstances where Approved Establishment managers may restrict visitors, refuse them entry or require them to leave. Managers should have a policy on the circumstances in which visits to patients may be restricted, to which both clinical staff and patients may refer, which should be clearly displayed on the ward.
- 9.11 There are two principal grounds which could justify the restriction or exclusion of a visitor: clinical grounds and security grounds.
- 9.12 The decision to prohibit a visit by any person whom the patient has requested to visit or has agreed to see should be regarded as a serious interference with the rights of the patient and a blanket restriction may be considered a breach of their Article 8 ECHR rights. There may be circumstances when a visitor has to be excluded, but these instances should be exceptional and any decision should be taken only after other means to deal with the problem have been considered and (where appropriate) tried. Any such decision should be fully documented and include the reasons for the exclusion. Such reasons must be explained to the patient. Approved Establishment managers should review the effect on the patient of any decision to restrict visits. These policies should be risk-based and not impose blanket restrictions.

Restriction or exclusion on clinical grounds

- 9.13 From time to time, the patient's RMO may decide, after assessment and discussion with the multi-disciplinary team, that some visits could be detrimental to the safety or wellbeing of the patient, the visitor, other patients or staff on the ward. In these circumstances, the RMO may make special arrangements for the visit, impose reasonable conditions or if necessary exclude the visitor. In any of these cases, the reasons for the restriction should be recorded and explained to the patient and the visitor, both orally and in writing (subject to the normal considerations of patient confidentiality). Wherever possible, 24-hour notice should be given of this decision.

Restriction or exclusion on security grounds

9.14 The behaviour of a particular visitor may be disruptive, or may have been disruptive in the past, to the degree that exclusion from the hospital is necessary as a last resort. Examples of such behaviour include:

- incitement to abscond
- smuggling of illicit drugs or alcohol into the hospital or unit
- transfer of potential weapons
- posing a risk to the patient, other patients and/or staff, and
- attempts by members of the media to gain unauthorised access.

9.15 A decision to exclude a visitor on the grounds of their behaviour should be fully documented and explained to the patient orally and in writing. Where possible and appropriate, the reason for the decision should be communicated to the person being excluded (subject to the normal considerations of patient confidentiality and any overriding security concerns).

Monitoring by Approved Establishment managers

9.16 Approved Establishment managers should regularly monitor the exclusion from the hospital of visitors to detained patients.

Children and young people

9.17 All hospitals should have written policies and procedures regarding the arrangements for children and young people who visit patients in hospital and for visits to patients who are children or young people.

9.18 Local policies should ensure that the welfare and safety of the children and young people concerned are always considered and that visits by children and young people are prevented if they are not in their best interests. Within that overarching framework, and subject to risk assessments, hospitals should do all they can to facilitate the maintenance of children and young people's contact with friends and family and offer privacy within which that can happen.

9.19 Information about visiting should be explained to children and young people in a way that they are able to understand. Environments that are friendly to children and young people should be provided where possible.

9.20 Where a child or young person is being detained, it should not be assumed, because of their age, that they would welcome all visitors, and, like adults, their views should be sought.



Chapter 10: Wishes expressed in advance

Chapter 10

Definitions.....	68
Advance decision to refuse treatment.....	68
Advance statements.....	69
Advance statement of wishes and feelings.....	70

Chapter 10: Wishes expressed in advance

10.1 This Chapter gives guidance on statements by patients who are subject to compulsory measures under the Law about their preferences for what they would or would not like to happen if particular situations arise in the future. These include an Advance Decision to Refuse Treatment (ADRT) and Advance Statements.

Definitions

10.2 This Chapter distinguishes between advance decisions to refuse medical treatment and other statements of views, wishes and feelings that patients make in advance. Such statements can only be created by a patient with capacity and cannot be created by any third party.

Advance decision to refuse treatment

10.3 An advance decision to refuse treatment (ADRT) means a decision to refuse specified medical treatment in advance by a person, aged 16 or over, who has the capacity to do so at the time the ADRT is made. ADRT's are a way in which people can refuse medical treatment for a time in the future when they may lack the capacity to consent or refuse that treatment, as detailed in the Capacity Law. ADRT's are, in practice, used for medical procedures and matters pertaining to medical needs.

10.4 An ADRT is legally binding in Jersey under the Capacity Law, as long as it is 'valid' and 'applicable'. This means that if any healthcare professional knows you have made an ADRT, they have to follow it. If they ignore such an ADRT they could be taken to court.

10.5 In certain circumstances, described in Chapter 17, the Law allows patients to be given medical treatment for their mental disorder without their consent and therefore this would apply even though they have made a valid and applicable ADRT. This only applies to patients who are detained under the Law. On this basis, an ADRT is not the best means for patients to make advance decisions about their future mental health treatment and patients should be encouraged to use an Advance Statement.

10.6 The Law does not authorise disregard for valid and applicable ADRT's made by detained patients with regard to refusing treatment which is not for mental disorder.

Advance statements

- 10.7** Similarly to ADRT, an advance statement (AS) is made at a time when patients, who have capacity to make decisions at that time about how they wish to be treated, or wish not to be treated in the future, during periods when their mental disorder affects their ability to make decisions about treatment.
- 10.8** Any patient who can understand what they are putting in the AS and the effect it might have on their future treatment, can make an AS.
- 10.9** To be valid and applicable, an AS must be signed by the patient and witnessed by a professional who is involved in the patient's care and treatment. The witness must sign to confirm the patient's statement was made at a time when they had capacity to determine what is detailed within the statement.
- 10.10** The AS is not legally binding but aims to empower patient's, giving a mechanism where their views regarding treatment and care are given due regard, whilst acknowledging that their choices may not be adhered to. It upholds the ethos that people with mental health conditions are equally entitled to control their health and mental health care.
- 10.11** Encouraging patients to set out their wishes in writing in advance will often be a helpful therapeutic tool, promoting collaboration and trust between patients and professionals. This promotes the recognition that a patient is the expert in the management of their own condition.
- 10.12** Whenever expressing a preference for their future treatment and care, patients should be encouraged to be as precise as possible regarding future circumstances. For example, being given a particular type of treatment or being restrained in a particular way, patients should be encouraged to give their views on what should be done instead.
- 10.13** An AS is not the only means of ascertaining a patient's past and present wishes and feelings and other relevant sources of information should be taken into account when decisions are being made about care and treatment, whether an AS exists or not.
- 10.14** If a valid and applicable AS exists, it has the same effect as if the patient has capacity and makes a contemporaneous decision about treatment. However, when an AS is not followed, the RMO, or relevant professional, should record the reason for the decision which is contrary to the patient's AS on the appropriate document. This must be added to the patient's record. A decision not to adhere to an AS is a serious matter and such decisions should not be taken lightly. In such an instance the RMO should ensure that the rationale is shared with both the patient and their Nearest Person. A copy of the document must be made available to the Administrator.

10.15 Even where RMOs may lawfully treat a patient compulsorily under the Law, they should try to comply with the patient's wishes as expressed in an AS. They should, for example, consider whether it is possible to use a different form of treatment not refused by the AS.

Advance statement of wishes and feelings

10.16 There may be times when, because of their mental disorder, patients who are subject to compulsory measures under the Law are unable or unwilling to express their views or participate as fully as they otherwise would in decisions about their care or treatment under the Law. In such cases, patients' past wishes and feelings – so far as they are known – take on greater significance.

10.17 Some patients will state their wishes in advance about a variety of issues, such as the steps that should be taken in emergencies and what should be done if particular situations occur. Such wishes should be given the same consideration as wishes expressed at any other time.

10.18 When working together with a patient to create an AS, an advance statement of wishes and feelings can be incorporated.

10.19 Patients should, however, be made aware that expressing their preference for a particular form of treatment or care in advance like this does not legally compel professionals to meet that preference.

10.20 Where patients express views to any of the professionals involved in their care about how they should be treated or about ways they would not wish to be treated in future, the professional should note those views in the patient's records. If the views are provided in a written form, they should be kept with the patient's records and highlight this clearly for other allied health professionals to whom the information is relevant for the delivery of care and treatment.

10.21 If the professional to whom the wish is being expressed forms the opinion that the patient lacks capacity to understand the wish they are expressing, the professional should record their opinion, and their reasons for it, alongside the record of the patient's wish.

10.22 Although a patient has expressed their wishes about a particular matter in the past, this is not a substitute for seeking their views on it when the situation actually arises. In particular, where patients have the capacity to express a clear wish in the present, that wish should always be assumed to have overtaken their previous wishes, even if it is significantly different.



Chapter 11: The Mental Health Review Tribunal

Chapter 11

Function of the Tribunal	72
Applications to the Tribunal	72
Informing the patient of their right to apply to the Tribunal	73
Reports – general	74
Medical examination	76
Visits by other Tribunal members and representatives	76
Withdrawing the application	77
Representation	77
The Hearing	78

Chapter 11: The Mental Health Review Tribunal

11.1 This Chapter gives guidance on the role of the Mental Health Review Tribunal and of the related duties of Approved Establishment managers and others.

Function of the Tribunal

11.2 The Tribunal is an independent judicial body which provides a significant safeguard for patients who have had their liberty curtailed under the Law. Its main function is to review the cases of detained patients under the Law including those granted long-term or indefinite leave according to Article 24, and to direct the discharge of any patients where it thinks it appropriate.

11.3 Those involved in the hearing should actively contribute in supporting the Tribunal to conduct its processes in a professional manner, including having regard to the patient's wishes and feelings, and ensuring that the patient feels as comfortable with the proceedings as possible.

11.4 It is for those who believe that a patient should continue to be detained to prove their case, not for the patient to disprove it. They will therefore need to present the Tribunal with sufficient evidence in the form of written clinical and social reports to support continued detention. Care should be given to ensure that all information is as clear, precise, concise and as up to date as possible to avoid adjournment.

Applications to the Tribunal

11.5 A patient may apply for a Tribunal hearing in a range of different circumstances. Their Nearest Person also has the right to apply for a Tribunal hearing. The circumstances under which a patient or their Nearest Person may apply for a Tribunal hearing are set out in Part 2 of the Schedule which forms part of the Law. The associated timescales for such applications are also set out in the Schedule.

11.6 The only circumstances in which a person other than either the patient or their Nearest Person may apply to the Tribunal are these:

- when a decision has been taken to withhold a postal packet or its contents from a patient by the managers of an Approved Establishment. In such a circumstance, the person by whom the packet was sent may make an application to the Tribunal.
- when authorisation is needed in order for a person to be removed from Jersey. In such a circumstance the Minister may make an application to the Tribunal.

There may be circumstances where a patient who would be eligible to make an application to the Tribunal lacks the capacity to make this decision. In such circumstances a formal assessment of the patient's capacity in respect of the matter would need to be undertaken. If it is determined that the patient lacks capacity, a best interest decision could be made by the Attorney General following the process as set out in the Capacity Law and its accompanying Code of Practice. The patient's Nearest Relative should be involved in this decision unless there are specific reasons pertaining to why this cannot take place. Typically such a reason would be that the patient does not have a Nearest Relative.

11.7 No other third party can make an application to the Tribunal on behalf of the patient.

11.8 In situations where a patient's capacity fluctuates, a determination will need to be made in respect of whether the patient has the capacity to request (or to decline) an application to the Tribunal. Such a determination would need to be made on the balance of probabilities in line with the Capacity Law and its accompanying Code of Practice. Documentation should be collated in respect of the steps taken to enhance the person's ability to make the decision and provided to the Tribunal Service if requested.

Informing the patient of their right to apply to the Tribunal

11.9 The Department and Approved Establishment managers are under a duty to ensure that patients understand their rights to apply for a Tribunal hearing. The Department and Approved Establishment managers should also advise patients of the availability of funded representation. They should do both whenever:

- patients are first detained in an Approved Establishment;
- their detention is renewed; and
- their status under the Law changes – for example, if they move from detention under Article 21 to detention under Article 22.

- 11**
- 11.10** Funded representation for the Tribunal is not means tested and is available to all detained patients.
- 11.11** Unless the patient requests otherwise, the information should normally also be given to their Nearest Person (subject to the normal considerations about involving Nearest Person).
- 11.12** Approved Establishment managers and professionals should enable detained patients to be visited by their legal representatives at any reasonable time. This is particularly important where visits are necessary to discuss a Tribunal application. Where the patient consents, legal representatives and independent doctors should be given prompt access to the patient's medical records. Delays in providing access can hold up the Tribunal proceedings and should be avoided.
- 11.13** In connection with an application or reference to the Tribunal, an independent doctor authorised by (or on behalf of) a patient has a right to visit and examine the patient in private. Those doctors also have a right to inspect records relating to the patient's detention, treatment and aftercare plans. The patient's consent is not required for authorised doctors to see their records, and they should be given prompt access to the records they wish to see.

Reports – general

- 11.14** Approved Establishment managers and the Department should be familiar with the Tribunal's rules and procedures. The rules place a statutory duty on the Department to provide the Tribunal with a statement of relevant facts together with certain reports.
- 11.15** It is important that written documents and information are provided in accordance with the Tribunal's rules and procedures in good time for any Tribunal hearing. Missing, out of date or inadequate reports can lead to adjournments or unnecessarily long hearings. Where medical practitioners, social workers and other professionals are required to provide reports, they should do this promptly and within the timescale given.
- 11.16** Tribunal hearings can be requested for assessment authorisations. Professionals will be notified of the requirement for written reports in advance. Notification will be seven days prior to the Tribunal hearing for assessment authorisations. Reports must be submitted to the Tribunal Service two days prior to the Tribunal hearing, through the Administrator.
- 11.17** Tribunal hearings can also be requested for treatment authorisations. Professionals will be notified of the requirement for reports in advance. Notification will be twenty-eight days prior to the Tribunal hearing for treatment authorisations. Reports must be submitted to the Tribunal Service seven days prior to the Tribunal hearing, through the Administrator.

- 11.18** In exceptional circumstances, such as the transfer of patients to other jurisdictions, the Tribunal Chair may require reports outside of these timescales. In such circumstances written reports are preferred, however, oral evidence can be used to provide additional information.
- 11.19** Report writers can request that certain information be withheld. There are two reasons this can be requested, safeguarding and a detrimental impact on the patient's mental health. If information is withheld due to safeguarding issues, it can be withheld from both the patient and the Nearest Person but only for as long as the level of risk remains high. For information that is likely to be to the detriment of the patient's mental health, this can only be withheld from the patient but only for as long as the level of risk remains high. The decision to share or withhold the information is the decision of the Tribunal.
- 11.20** In the case of a restricted patient, if the opinion of the medical practitioner or other professional changes from what was recorded in the original Tribunal report(s), it is vital this is communicated in writing, prior to the hearing, to the Tribunal Chair in order to facilitate the opportunity for the preparing of a supplementary statement.
- 11.21** If the Tribunal feels that it needs more information on any report, it may request it, either in the form of a supplementary report or by questioning a witness at the hearing itself.
- 11.22** In some circumstances, the Tribunal will not sit immediately after receiving the reports. In these cases, the report writers should consider whether anything in the patient's circumstances have changed and should produce a concise update to the report. This is especially important if a patient's legal status changes – for example, if a patient moves from detention under Article 21 to Article 22.
- 11.23** In those cases, the application will need to be considered under the new circumstances, and the report will need to provide a justification for continued detention or liability to recall under the new circumstances. The Tribunal may ask the report writer to talk through it, so it is a good practice for the writer to re-familiarise themselves with the content of any report before the hearing. If the report writer of the report is unable to attend, it is important that anyone attending in their place should, wherever possible, also have a good knowledge of the patient's case.
- 11.24** Approved Establishment managers and the Department should ensure that the Tribunal is notified immediately of any events or changes that might have a bearing on Tribunal proceedings – for example, where a patient is discharged or one of the parties is unavailable.

- 11.25** If the writer of a report prepared for the Tribunal is aware of any information they do not think the patient should see, they should follow the Tribunal's procedure for the submission of such information. Ultimately, it is for the Tribunal to decide what should be disclosed to the patient.
- 11.26** Reports should be sent to the Tribunal Administrator, via the Mental Health Law Administrator preferably by secure email or by registered post.
- 11.27** The Approved Establishment managers and the Department must ensure that up-to-date reports prepared specifically for the Tribunal are provided in accordance with the Tribunal's rules and procedures. In practice, this will normally include a report completed by the patient's medical practitioner. Where the patient is under the age of 18 and the medical practitioner is not a CAMHS specialist, Approved Establishment managers should request that a report is prepared by a CAMHS specialist.
- 11.28** Approved Establishment managers and the Department must allow all medical practitioners, social workers and other professionals involved in a Tribunal hearing adequate provision of support and sufficient time to plan, research and write the Tribunal report.
- 11.29** Where possible, reports should be written by the professionals with the best overall knowledge of the patient's situation.

Medical examination

- 11.30** A medical member of the Tribunal may examine the patient at any time before the hearing. Approved Establishment managers must ensure that the medical member can see patients who are in an Approved Establishment in private and in an appropriate environment. The medical member may also examine their medical records. It is important that the patient is told of the visit in advance so that they can be available when the medical member visits.

Visits by other Tribunal members and representatives

- 11.31** Tribunal members and the patient's legal representative have the right to visit prior to the Tribunal. Approved Establishment managers must ensure that the Tribunal members can see the patient who is in an Approved Establishment in private and in an appropriate environment, if it is safe to do so. It is important that the patient is told of any visits in advance so that they can be available. Legal representatives have the right to see records if they have the permission of the patient.

11.32 Approved Establishment managers must ensure that the safety of all Tribunal members and representatives is considered prior to the organisation of any visits. Any limitation on seeing the patient in private must be reviewed in line with the principle of the least restrictive approach and consideration of the patient's privacy. Where there are known safety concerns in relation to other people, risk assessments, whether verbal or written must be undertaken in conjunction with the Tribunal Service.

Withdrawing the application

11.33 A request to withdraw an application may be made by the applicant in accordance with the Tribunal rules. If a patient already has a legal representative, they will visit to discuss the implications of withdrawal. For patients who have not been appointed a legal representative one will be offered to support this discussion. If the patient declines all legal representation, a further offer of an IMHA will be made prior to the withdrawal application being progressed.

11.34 An application will also be considered to be withdrawn if the patient is discharged. If this happens outside office hours, someone acting on behalf of the Approved Establishment managers should contact the Tribunal Administrator as soon as possible, to inform them. For detained patients, this could be done by a member of the ward staff.

11.35 Withdrawing an application for an upcoming Tribunal is a judicial decision, not an administrative one, therefore the Tribunal Chair will need to decide whether or not to accept the withdrawal. The Tribunal Service will inform all relevant parties whether the withdrawal has been accepted or if further information is needed in order to satisfy the Tribunal Chair that it is in the patient's best interests to withdraw.

Representation

11.36 Approved Establishment managers should inform patients of their right to present their own case to the Tribunal and their right to be represented by someone else (such as an IMHA). Staff should be available to help patients make an application. This is especially important for patients subject to indefinite Article 24 leave who may not have daily contact with professionals.

11.37 On rare occasions, the Tribunal may still appoint a legal representative if there are concerns that the representations made by the patient or their chosen person would be detrimental to the Tribunal's understanding of the patient's needs. Any decision to appoint without the patient's consent would follow best interest process in the Capacity Law and could only happen at all if the patient was assessed as having the capacity to make the relevant decision.

The Hearing

Attendance at hearings

- 11.38** A patient may be present throughout their Tribunal hearing and must always be invited to it. Patients do not need to attend their hearing, but professionals should encourage them to attend unless they judge that it would be detrimental to their health or wellbeing. Detrimental is to be interpreted as being likely to cause actual harm. That a patient might find a hearing to be an upsetting process is not the same as being detrimental.
- 11.39** It is important that the patient's RMO attends the Tribunal, supported by other staff involved in the patient's care where appropriate, as their evidence is crucial for making the case for the patient's continued detention under the Law. Wherever possible, the RMO and other relevant staff should attend for the full hearing so that they are aware of all the evidence made available to the Tribunal and of the Tribunal's decision and reasons.
- 11.40** The Tribunal would expect professional attendees to have seen the patient in the last two working days. There may be times when this is impractical or the patient will decline to meet with some professionals.
- 11.41** It is important that other people who prepare reports submitted by the Department attend the hearing to provide further up-to-date information about the patient, including (where relevant) their home circumstances and the after-care available in the event of a decision to discharge the patient.
- 11.42** Increasingly, the Tribunal find it helpful to speak to a nurse, particularly a nurse who knows the patient. It is therefore often helpful for a nurse who knows the patient to accompany them to the hearing.
- 11.43** The Tribunal may request other professionals attend in order that they have access to appropriate, relevant and up-to-date information to make decisions about a patient.
- 11.44** Approved Establishment managers and the Department should ensure that all professionals who attend Tribunal hearings on their behalf are adequately supported and prepared.

Accommodation for hearings

- 11.45** The managers of an Approved Establishment in which a Tribunal hearing is to be held should provide suitable accommodation for that purpose. The hearing room should be private, quiet, clean and adequately sized and furnished. It should not contain confidential information about other patients.

- 11.46** The patient should have access to a separate room in which to hold any private discussions that are necessary, for example, with their representative; as should the Tribunal members, so that they can discuss their decision.
- 11.47** Where a patient is being treated in the community (being subject to leave of absence), the Approved Establishment managers should consider whether an Approved Establishment venue is appropriate. They may wish to discuss alternatives with the Tribunal Administrator.

Interpretation

- 11.48** Where necessary, interpretation services will be provided free of charge for patients.

11

Communication of the decision

- 11.49** The Tribunal will normally communicate its decision to all parties orally at the end of the hearing. Provided it is feasible to do so, and the patient wishes it, the Tribunal will speak to them personally. Otherwise, the decision will be given to the patient's representative. If the patient is unrepresented, and it is not feasible to discuss matters with them after the hearing, the Approved Establishment managers should ensure that they are told the decision as soon as possible. Copies of the decision should be sent to all parties within five days of the hearing. This may be done electronically. Written reasons for the decision will be sent to all parties within fourteen days of the Tribunal hearing.

Complaints

- 11.50** Complaints from users about the Tribunal should be sent, via the Tribunal Administrator, to the Tribunal Chair, who will deal with the complaint promptly.

Further information on the Tribunal

- 11.51** Regard should be had to any practice directions or other further information and guidance issued by the Tribunal about its procedures and operations.

Section 3: Assessment, Transport and Admission to hospital

Why read this section?

These chapters address the legal framework which governs a patient's assessment and admission to an approved establishment. Guidance is provided in respect of applications for detention under the Law, including emergency detention and conveyance of a patient to an approved establishment. Guidance is also provided in respect of the Capacity and Self-Determination Law 2016 and the circumstances under which a significant restriction on liberty might be authorised instead of making an application under the Law.



Chapter 12: Applications for detention in Approved Establishments

Chapter 12

Criteria for applications.....	83
Factors to consider – the health or safety of the patient.....	84
Factors to consider – protection of others.....	85
Alternatives to detention – patients with capacity to consent to admission.....	85
Patients who lack capacity to consent to admission or treatment.....	86
Deciding between detaining a person for assessment or treatment.....	86
The assessment process.....	87
Objective of the assessment.....	89
Setting up the assessment.....	89
The role of AOs.....	90
The AO and the Nominated Representative/Nearest Person.....	92
Consultation with other people.....	93
Medical examination by doctors as part of the assessment.....	93
Communicating the outcome of the assessment.....	94
Action when it is decided not to apply for detention.....	95
Action when it is decided to make an application.....	96
Resolving disagreements.....	97
Patients who are deaf.....	97
Renewal of assessment authorisations.....	97
Renewal of treatment authorisations.....	98

Chapter 12: Applications for detention in Approved Establishments

- 12.1** This Chapter gives guidance on the making of applications for detention in Approved Establishments under Part 3 of the Law.
- 12.2** An application for detention may only be made where the grounds in either Article 21 or Article 22 are met.

Criteria for applications

- 12.3** A person can be detained for assessment under Article 21 only if both of the following criteria apply:

- 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 with or without treatment, for at least a limited period; and
- it is necessary – in the interests of the patient’s health or safety, or for the protection of others that the patient should be so detained.

- 12.4** A person can be detained for treatment under Article 22 only if all the following criteria apply:

- 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
- it is necessary in the interests of the patient’s health and safety or for the protection of other persons that the patient should be so detained.

- 12.5** The criteria requires consideration of both the nature and degree of a patient’s mental disorder. Nature refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis (which may be related to the patient’s previous response to treatment). Degree refers to the current manifestation of the patient’s disorder.

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

12.7 In all cases, consideration must be given to:

- the patient's wishes and view of their own needs;
- the patient's age and physical health;
- any past wishes or feelings expressed by the patient, in accordance with the respect principle;
- the patient's cultural background;
- the patient's social and family background;
- the impact that any future deterioration or lack of improvement in the patient's condition would have on their children, other relatives or carers, especially those living with the patient, including an assessment of these people's ability and willingness to cope; and
- the effect on the patient, and those close to the patient, of a decision to admit or not to admit under the Law.

Factors to consider – the health or safety of the patient

12.8 Factors to be considered in deciding whether a patient should be detained for their own health or safety include:

- any evidence suggesting that the patient is at risk of:
 - suicide
 - self-harm
 - self-neglect or being unable to look after their own health or safety
 - jeopardising their own health or safety accidentally, recklessly or unintentionally, or
 - that their mental disorder is otherwise putting their health or safety at risk.
- any evidence suggesting that the patient's mental health will deteriorate if they do not receive treatment;
- the reliability of such evidence, including what is known of the history of the patient's mental disorder;
- the views of the patient and of any carers, relatives or close friends, especially those living with the patient, about the likely course of the disorder and the possibility of it improving;

- the patient's own skills and experience in managing their condition;
- the potential benefits of treatment, which should be weighed against any adverse effects that being detained might have on the patient's wellbeing; and
- whether other methods of managing the risk are available.

Factors to consider – protection of others

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

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

Data-sharing arrangements will need to be developed in order to support the above.

12.10 Harm to other people includes psychological as well as physical harm.

Alternatives to detention – patients with capacity to consent to admission

12.11 A patient may need admission to an Approved Establishment. The patient may have the capacity to consent to informal admission and may decide to do so. In such situations, informal admission will normally be appropriate. However, there are exceptions to this. If the reason for considering admission is that the patient presents a clear risk to themselves or others because of their mental disorder, formal admission may be more appropriate. The rationale for determining to make an application for admission in such circumstances must be thoroughly recorded.

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

12.13 The threat of detention must not be used to coerce a patient into consenting to admission to an Approved Establishment or to treatment (and is likely to invalidate any apparent consent).

Patients who lack capacity to consent to admission or treatment

12.14 The Law does not allow for the informal admission to an Approved Establishment for treatment of those patients who do not have the capacity to consent to it. Therefore if admission to an Approved Establishment for treatment is necessary then compulsory admission is the only option available and should be considered in accordance with usual processes. Best interests processes and use of the Capacity Law should not be considered when admitting a patient to an Approved Establishment for assessment or treatment of mental illness.

12

Deciding between detaining a person for assessment or treatment

12.15 An application for the detention of a person can be made for assessment (Article 21) or treatment (Article 22). A person may meet the criteria for detention according to either Article in which case a decision will need to be made to determine between the two.

12.16 Article 21 should be used when:

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

12.17 Article 22 should be used when:

- the patient is already detained under Article 21 (detention under Article 21 is for up to 28 days and cannot be renewed), and/or when
- the nature and current degree of the patient's mental disorder, the essential elements of the treatment plan to be followed and the likelihood of the patient accepting treatment on a voluntary basis are already established. In such cases it would be anticipated that no significant changes to the pre-existing treatment plan would be made during the patient's admission.

Whilst Article 22 is available in such cases, it does not negate the possibility that the patient might benefit from a new assessment. Article 21 may be the least restrictive outcome and may be in the best interests of some patients. The rationale for making use of either article should be clearly recorded by each of the doctors who are making medical recommendations and by the AO who is making the application.

12

The assessment process

12.18 An application for detention under either Article 21 or 22 may be made by the AO upon having received two medical recommendations. The recommendations must be completed by both of the below:

- a registered medical practitioner who is an approved practitioner;
- a second registered medical practitioner who is either a psychiatrist or any other doctor.

The recommendations may be made separately or jointly.

12.19 Where possible, the approved practitioner should have previous acquaintance with the patient. In the event that both of the recommending doctors are approved practitioners it is only anticipated that one of these doctors has such previous acquaintance. It is acknowledged that there will be occasions when neither of the doctors has such previous acquaintance. In which case, this must be documented in the assessment records.

12.20 In the event that the patient is a child or young person, a paediatric consultant psychiatrist should provide one of the recommendations. Where this is not possible, a paediatrician should provide one of the recommendations. In the event of an emergency, it is permissible that neither of the doctors has expertise in treating children or young people.

12.21 In the event that the patient is over the age of 65, one of the doctors should have specialist knowledge of older adults' mental health. In the event of an emergency, it is permissible that neither of the doctors has expertise in older adults' mental health.

- 12.22** In the event that the patient has a diagnosed learning disability or a diagnosis of Autism Spectrum Disorder/Asperger's Syndrome one of the doctors should have a specialist knowledge of learning disabilities or ASD/Asperger's Syndrome (as appropriate). In the event of an emergency, it is permissible that neither of the doctors has such expertise.
- 12.23** In respect of 12.20-22, if it is not feasible to obtain specific expertise at the time of the assessment, at least one of the professionals involved in the person's assessment should, if at all possible, consult with one or more professionals who do have relevant expertise and involve them as closely as the circumstances of the case permits.
- 12.24** Where a recommendation is made by an AP who is a General Practitioner, they should firstly discuss their findings with the patient's RMO (if there is one) or another psychiatrist.
- 12.25** Although it is permissible and sometimes necessary that the doctors may assess separately, all efforts should be made to coordinate an assessment of the patient jointly. This is intended to facilitate collaborative practice and the free and open sharing of professional opinions. This is of particular importance when one of the doctors has a knowledge of the patient's case, diagnosis, risk or treatment plan and the other doctor does not. Additionally, it is likely to be of significant benefit to the patient that they can be assessed jointly in order to prevent the patient being required to repeat information to multiple professionals.
- 12.26** Patients should, where possible, be seen jointly by the AO and the doctors involved in the assessment. However, the AO is required to operate independently of the doctors and may, depending upon the circumstances of the case, request that medical recommendations are completed prior to them meeting the patient.
- 12.27** In the event that either or both doctors determine not to make medical recommendations, the patient should still be seen by an AO. In such circumstance the patient will either be discharged, remain in police custody or remain in hospital as a voluntary patient. In order for a patient to be detained under the Law, there must be agreement from all three professionals involved in the assessment.
- 12.28** Documentation pertaining to the assessment must be completed comprehensively and in a timely manner. In the event that documentation is not completed at the time of the assessment, as a minimum the outcome of the assessment and a description of the associated plan must be recorded electronically at the earliest opportunity which will usually be at the time that the assessment is completed.

Objective of the assessment

- 12.29** The objective of the assessment is to determine whether the criteria for detention are met and, if so, whether an application for detention should be made.
- 12.30** That the criteria for detention are met does not in itself indicate that an application for detention should be made.
- 12.31** A comprehensive assessment cannot be carried out without considering alternative means of providing care and treatment. Therefore, AOs and doctors should, as far as possible in the circumstances, identify and liaise with services which may potentially be able to provide alternatives to admission to an Approved Establishment. That could include crisis and home treatment interventions.
- 12.32** In the event that either the doctors and/or the AO identify that a service which could be provided which might reasonably be anticipated to reduce the need for hospital admission in respect of a given patient, this should be recorded and communicated to a relevant manager.

12

Setting up the assessment

- 12.33** AOs who assess patients for possible detention under the Law have overall responsibility for co-ordinating the process of assessment. However, in practice the various roles associated with this coordination may be shared.
- 12.34** In coordinating the assessment, the AO must be sensitive to the patient's age, sex, gender identity, social, cultural, racial and religious background and sexual orientation. They should also consider how any disability the patient has may affect the way the assessment needs to be carried out.
- 12.35** It is essential that those who assess patients are able to communicate with the patient effectively in order to reduce the possibility of potential misunderstandings. AOs should establish, as far as possible, whether patients have particular communication needs or difficulties and take steps to meet them, for example by arranging a signer or a professional interpreter.
- 12.36** See paragraphs 12.78-12.80 for specific guidance in relation to the assessment of people who are deaf. For further guidance on specific issues that may arise when assessing people who have an autism spectrum disorder, a learning disability, or a personality disorder, see Chapters 3, 18 and Chapter 19 respectively.
- 12.37** Doctors and AOs undertaking assessments need to apply professional judgement and reach decisions independently of each other, but in a framework of cooperation, professional respect and mutual support.

12.38 It is best practice and is strongly recommended that the two doctors undertaking the assessment are not members of the same team and in particular do not have supervisory responsibilities in respect of each other. It is acknowledged that this is sometimes difficult to uphold given the limited resources within an island community. Therefore, it is crucial that a 'culture of openness' is adopted where all opinions in such assessments are embraced and that all parties understand that differences of professional opinion and judgement may exist and are to be encouraged within the assessment process. Ultimately the AO is the decision-maker in respect of whether an application is made and the resultant decision must be respected by all involved.

12.39 Everyone involved in an assessment should be attuned to the need to provide support for colleagues, especially where there is a risk of the patient causing physical harm. People carrying out assessments should be aware of circumstances in which the police should be asked to provide assistance, in accordance with arrangements agreed with the police, and of how to use that assistance to maximise the safety of everyone involved in the assessment. Notwithstanding the importance of patient-centred care, the safety of staff members is of equal importance.

12.40 On occasions where it is anticipated that the attendance of the police may be required, prior discussions should help determine the nature, level and degree of risk, what police assistance may be required and how quickly it is needed. It is important to share relevant information about the patient in order that police colleagues can fully contribute to the risk assessment. In cases where no warrant for the police to enter premises under Article 35 of the Law is being applied for (see Chapter 13), the risk assessment should indicate the reasons for this and explain why police assistance is nonetheless necessary. Agreed arrangements on the involvement of the police should later be recorded on the relevant record.

The role of AOs

12.41 AOs may make an application for detention only if they:

- have interviewed the patient in a suitable manner;
- are satisfied that the statutory criteria for detention are met;
- are satisfied that, in all the circumstances of the case, detention in an Approved Establishment is the most appropriate way of providing the care and medical treatment the patient needs; and
- are of the opinion, having regard to any wishes expressed by relatives, those closest to the patient or any other relevant circumstances, that it is necessary or proper.

- 12.42** There is no statutory maximum period between the completion of the second medical recommendation (or joint medical recommendation), and the completion of the application for admission by the AO. The Law states that the AO must complete their application within a period not exceeding seven days since they last saw the patient. In practice it is anticipated that the AO will complete their recommendation within seven days of the completion of the second medical recommendation (or joint medical recommendation).
- 12.43** At the start of the assessment, AOs should identify themselves to the person being assessed, members of the person's family, carers or friends and the other professionals present. AOs should ensure that the purpose of the visit, their role and that of the other professionals are explained. The AO must consult with the patient's Nearest Person prior to making an application unless such consultation would be impracticable or would involve unreasonable delay. In such instances, the fact that the Nearest Person has not been consulted and the reasons for this must be clearly documented by the AO.
- 12.44** Although AOs act on behalf of the Department, they cannot be instructed by the Department or anyone else whether or not to make an application. They must form their own judgement, based upon the social context and medical evidence, when deciding whether to apply for a patient to be detained under the Law. The role of AOs is to provide an independent decision about whether or not there are alternatives to detention under the Law.
- 12.45** If patients want someone else (e.g. a familiar person) to be present during the assessment and any subsequent action that may be taken, then ordinarily AOs should assist in securing that person's attendance, unless the urgency of the case makes it inappropriate to do so.
- 12.46** Patients should usually be given the opportunity to speak to the AO alone. However, if the AO has reason to fear physical harm, the AO should insist that another professional is present.
- 12.47** It is not desirable for patients to be interviewed through a closed door or window; this should be considered only when other people are at serious risk. Where direct access to the patient is not possible, but there is no immediate risk of physical danger to the patient or to anyone else, AOs should consider applying for a warrant under Article 35 of the Law (see Chapter 13).
- 12.48** Where patients are subject to the short term effects of alcohol or drugs (whether prescribed or self-administered), which make interviewing them difficult, the assessing team should form a view about the person's capacity to engage in the assessment process. Having formed such a

view, the assessing team may either determine to interview the patient or to return later. Consumption of alcohol or use of substances is not in itself sufficient reason not to interview a patient. There may be circumstances in which the person is deemed to be unfit to interview but it is not realistic to wait until they become so on account of the patient's disturbed behaviour and the urgency of the case. In such an event any decisions will have to be based on the information the assessing team can obtain from reliable sources at the time. If the assessment was compromised as a result, this should be made clear in case recordings.

The AO and the Nominated Representative/Nearest Person

12.49 When AOs make an application for detention under the Law they must take such steps as are practicable to inform the Nearest Person that the application is to be (or has been) made. They should inform the Nearest Person of the power to appeal against the detention but also explain that such an appeal will not necessarily be successful depending upon the circumstances of the case.

12.50 If the patient has not nominated a representative then the AO must attempt to identify the patient's Nearest Person as defined in Article 8 of the Law.

12.51 The AO is required to consult with the Nearest Person unless such consultation is either not reasonably practicable or if it would involve unreasonable delay.

Consultation is defined by the Code as the discussing of the application with the Nearest Person in order to obtain and record their opinions about it. The Nearest Person may be able to suggest alternatives to detention. However, there is no requirement for the AO to adhere to any wishes expressed by the Nearest Person.

The AO may consider the views of the Nearest Person and use these to inform their assessment.

The Nearest Person does not have the power to block an application to detain their relative although they may apply for their relative to be discharged. They can make such an application either to the RMO or to the Tribunal. It is possible for the Nearest Person to apply to both the RMO and the Tribunal and in respect of either an assessment or a treatment Article provided that the associated timescales are met.

Reasonably practicable is defined by the Code as achievable without undue difficulty. If it is practicable to identify and make contact with a person's nearest relative then this should normally take place unless there are considerations involving risk which need to be taken into account.

Unreasonable delay is defined by the Code as delay which would prevent an intervention taking place which needs to take place in the interests of the person's own health and/or safety and/or for the protection of others. Where an application needs to be made prior to consulting with the Nearest Person this can take place if there is suitable justification. In such cases, reasonable effort should be made to consult with the Nearest Person following the application.

Consultation with other people

12.52 Insofar as the urgency of the case allows, AOs should consider consulting with anyone named by the person and take their views into account.

12.53 Where patients are under 18, AOs should in particular consider consulting with the patient's parents (or other people who have parental responsibility for the patient). If such people are not consulted, the reasons for this must be documented.

12.54 In deciding whether it is appropriate to consult carers and other family members, AOs should consider: the patient's wishes; the nature of the relationship between the patient and the person in question, including how long the relationship has existed; and whether the patient has referred to any hostility between them and the person in question, or there is other evidence of hostility, abuse or exploitation.

12.55 AOs should also consult wherever possible with other people who have been involved with the patient's care. These could include people working for statutory, voluntary or independent services.

Medical examination by doctors as part of the assessment

12.56 A medical examination must involve:

- direct personal examination of the patient and their mental state; and
- consideration of all available relevant information, including that in the possession of others, professional or non-professional.

12.57 The medical recommendations must come from both an approved practitioner and another doctor. In relation to the second medical recommendation the following order of preference should be applied depending upon the circumstances and urgency of the case:

1. a doctor who has previous acquaintance with the patient;
2. an AP;
3. any other doctor.

12.58 Where doctors complete separate medical recommendations, the maximum period permitted between the two recommendations is five days. Therefore, the maximum period permitted including the date of the first medical recommendation and the date of the second medical recommendation is seven days.

12.59 It is the responsibility of the AP to ensure that a suitable bed is available and to liaise with the respective hospital or ward in order to ensure a seamless transition from the place where the assessment was undertaken to the ward upon which a bed is identified.

12.60 Doctors must give reasons for the opinions stated in their recommendations. When giving a clinical description of the patient's mental disorder as part of these reasons, doctors should include a description of the patient's symptoms and behaviour, not merely a diagnostic classification.

Communicating the outcome of the assessment

12.61 Having decided whether or not to make an application for detention, AOs should inform the patient, giving their reasons. Subject to the normal considerations of patient confidentiality, AOs should also give their decision and the reasons for it to:

- the patient's Nearest Person;
- the doctors involved in the assessment;
- the patient's Care Co-ordinator (if they have one); and
- the patient's GP, if they were not one of the doctors involved in the assessment.

Such information may be provided verbally or in writing. In the event that it is provided verbally, a record must be kept to demonstrate that the information has been provided.

If the patient does not consent to information being provided with their Nearest Person or their GP, the AO will need to balance the patient's right to privacy against the need to share information. There is no statutory obligation to provide information to a patient's Nearest Person or GP in the event that an application is not made.

Action when it is decided not to apply for detention

- 12.62** There is no obligation on the AO to make an application for detention even though the statutory criteria may be met. It is recognised that there may be strong differences of opinion in respect of this. However, neither the recommending doctors nor any other professionals are permitted to exert pressure upon an AO to ensure that an application is made. It is the legal responsibility of the AO to make the decision irrespective of the views of other professionals involved in the application for detention.
- 12.63** Where AO's decide not to apply for a patient's detention they should record the reasons for their decision. The decision should be supported, where necessary, by an alternative framework of care and treatment. AOs must decide how to pursue any actions which their assessment indicates are necessary to meet the needs of the patient. In many cases, the AO will identify that the patient requires the provision of specialist mental health or related services. The AO and the doctors involved in the assessment are responsible for ensuring that such services are made available to the patient at the earliest eventuality. The AO is not responsible for providing a service directly.
- 12.64** The steps to be taken to put in place any such arrangements for the patient's care and treatment, and any plans for reviewing them, should be recorded in writing and copies made available to all those who need them (subject to the normal considerations of patient confidentiality).
- 12.65** It is particularly important that the patient's Care Coordinator (if they have one) is fully involved in decisions about meeting the patient's needs. However it is recognised that this may not be possible to effect at the time that the assessment takes place. It should therefore take place as soon as is practicable following the assessment.
- 12.66** Arrangements should be made to ensure that information about assessments and their outcome is passed to professional colleagues, where appropriate, for example where an application for detention is not immediately necessary but might be in the future. This information will need to be available at short notice at any time of day or night. It is crucial that such information is shared in a way that enables immediate access. Specifically it must be recorded on an electronic system to which all relevant professionals have access.
- 12.67** If any agencies or professionals are likely to have difficulties in accessing a particular electronic system, consideration should be made of how to share information in an alternative medium e.g. it may be necessary to contact an agency by telephone or email to ensure that they are aware of any significant records to which they might not otherwise have access.

Action when it is decided to make an application

- 12.68** Most compulsory admissions require prompt action. Before making an application, AOs should ensure that appropriate arrangements are in place for the immediate care of any dependent children the patient may have and any adults who rely on the patient for care. Their needs should already have been considered as part of the assessment.
- 12.69** Wherever possible, the AO should try and ensure that practical arrangements are made to ensure patient's property is secure and that pets will be adequately cared for whilst the patient is in an Approved Establishment. However this is not the responsibility of the AO alone. Where possible the patient's Nearest Person and Care Coordinator should be involved in discussions respecting how to resolve any issues relating to safety and security of environment and the care of pets.
- 12.70** Applications for detention must be provided to The Administrator as soon as is practicable.
- 12.71** Once an application has been made, the patient should be conveyed to an Approved Establishment as soon as possible, if they are not already in the Approved Establishment. However, patients should not be moved until it is known that the Approved Establishment or a ward with an approved bed is willing to accept them.
- 12.72** A properly completed application for detention under the Law, with the required medical recommendation(s) and the granting of either an assessment or treatment authorisation by law, provides the applicant the authority to convey the patient to an Approved Establishment even if the patient does not wish to go. See Chapter 13 for further guidance on conveyance.
- 12.73** The AO should provide a verbal handover to the Approved Establishment at the time the patient is first admitted or detained, giving reasons for the application and details of any practical matters about the patient's circumstances which the Approved Establishment should know.
- 12.74** A formal Mental Health Law Assessment report must be completed after every assessment irrespective of outcome. This must be provided in the approved format and must be uploaded onto the electronic recording system within 24 hours of the assessment.
- 12.75** As the authorisation to detain will be granted on the information contained in the application, the AO must ensure the correct Approved Establishment is named. The order cannot be used to admit a patient to any Approved Establishment other than the one stated in the application (although once admitted a patient may be transferred to another Approved Establishment – see Chapter 14).

Resolving disagreements

- 12.76** Sometimes there will be differences of opinion between professionals involved in the assessment. There is nothing wrong with disagreements; handled properly they offer an opportunity to safeguard the interests of the patient by widening the discussion on the best way of meeting their needs. Doctors and AO's should be ready to consult other professionals (especially Care Coordinators and others involved with the patient's current care), whilst retaining the final responsibility for their decision. Where disagreements do occur, professionals should ensure that they discuss these with each other.
- 12.77** Where there is an unresolved disagreement about an application for detention, it is essential that the professionals do not abandon the patient. Instead they should agree and explore an alternative plan, if necessary on a temporary basis. Such a plan should include a risk assessment and identification of the arrangements for managing the risks. The alternative plan should be recorded in writing, as should the arrangements for reviewing it. Copies should be made available to all those who need them (subject to the normal considerations of patient confidentiality).

12

Patients who are deaf

- 12.78** Where possible, AOs and doctors assessing a deaf person, should try and seek assistance from specialists with appropriate expertise in mental health and deafness.
- 12.79** The AO involved in the assessment is responsible for booking and using qualified interpreters with, where possible, expertise in mental health interpreting.
- 12.80** Reliance on unqualified interpreters or health professionals with only limited signing skills should be avoided. Family members may (subject to the normal considerations about patient confidentiality) occasionally be able to assist a professional interpreter in understanding a patient's idiosyncratic use of language. However, family members should not ordinarily be relied upon in place of a professional interpreter, even if the patient is willing for them to be involved.

Renewal of assessment authorisations

- 12.81** An Article 21 assessment authorisation cannot be renewed or extended under any circumstances.

Renewal of treatment authorisations

- 12.82** An Article 22 treatment authorisation may be renewed for a further period of up to 6 months and thereafter for further periods of up to 12 months.
- 12.83** An application to renew an Article 22 treatment authorisation can be made no earlier than 2 months immediately prior to the cessation of the Article but may be made at any time within the same 2 months.
- 12.84** The patient's RMO must examine the patient and make a report to the Minister recommending that it remains necessary for detention to remain in place in the interests of the patient's health and/or safety and/or for the protection of others.
- 12.85** Upon receipt of such a report, the Minister must renew the treatment authorisation for the appropriate period and must also inform the patient and their Nearest Person of the recommendation and outcome.
- 12.86** The patient's RMO may also recommend to the Minister that the patient be discharged. In which case the RMO must discharge the patient, having completed all relevant documentation.
- 12.87** There is no requirement in the Law for a further Mental Health Law assessment in order to renew a treatment authorisation. However, it is to be regarded as best practice that a treatment authorisation only be renewed following a Mental Health Law assessment which concludes that renewal is necessary and in the best interests of the patient.



Chapter 13: Police powers and places of safety

Chapter 13

Article 35: Powers of search, entry and removal of persons to places of safety	100
Mentally disordered people found in public places.....	101
Protocol on the use of police powers and places of safety.....	102
Assessment at a place of safety	103
Record keeping.....	104
Monitoring the use of the Law	104
Rights of persons detained in places of safety	105
Place of safety and consent to treatment	105
Making necessary arrangements following assessment.....	105

Chapter 13: Police powers and places of safety

13.1 This Chapter deals with entry to premises under the Law and with powers temporarily to remove people who appear to be suffering from a mental disorder to a place of safety.

Article 35: Powers of search, entry and removal of persons to places of safety

13

13.2 An AO or the holder of any post specified in a warrant may use powers of entry under Article 35 of the Law when it is necessary to gain access to premises to remove a person who is believed to have a mental disorder and is not receiving proper care. This requires a Bailiff's warrant. The Bailiff may issue a warrant under Article 35 (2) only in response to an application from an AO.

13.3 The warrant gives the AO or any person specified in the warrant the right to enter the premises, by force if necessary. When acting on the warrant, the AO must be accompanied by a medical practitioner and may be accompanied by a police officer as well. The AO or any person specified in the warrant may then remove the person to a place of safety, where they can be detained for up to 72 hours from the time of their arrival.

13.4 Following entry under Article 35(2), the AO and medical practitioner between them should, if feasible, carry out a preliminary assessment of the person to determine whether they need to be assessed further for an application under the Law or for other arrangements for care or treatment. It may be possible to carry out any such further assessment in the premises themselves if the person agrees to this; otherwise, the person should be taken to a place of safety.

13.5 Article 35(2) provides that a warrant may be used to help return a patient who has absconded, or who needs to be conveyed to an Approved Establishment, if access to the premises where they are staying has been refused or is likely to be refused. (See Chapter 30 for detained guidance on patients who are absent from hospital without leave.)

- 13.6** Where an Article 35 warrant is used, the AO and the Department should ensure that an ambulance or other transport is available to take the person to the place of safety or to where they ought to be, in accordance with a locally agreed protocol on the transport of patients under the Law (see Chapter 14).
- 13.7** The Bailiff has to be satisfied that it is appropriate to issue a warrant. He is likely to ask applicants why a warrant is being sought, whether reasonable attempts to enter without a warrant have been made and, if not, why not. Applicants should provide documented reasons for seeking a warrant particularly in circumstances where they have not already tried to gain access.
- 13.8** The Bailiff will require explicit evidence that a person is believed to be suffering from a mental disorder. Additionally, the Bailiff will require information about the person's circumstances insofar that they have been, or are being, ill-treated or neglected by others. Alternatively the Bailiff may accept evidence that a person is unable to care for himself and is living alone. In particular, the Bailiff is likely to require sight of any psychiatric or medical reports, safeguarding documentation and risk assessments which relate to the circumstances in question.
- 13.9** Thought should be given to the choice of the place of safety before a warrant is applied for under Article 35. Appropriate planning should mean that it is unlikely that a police station will be used as a place of safety for people removed under Article 35 unless there is a high risk of violent behaviour which could not otherwise be safely contained.
- 13.10** A warrant will not normally be required if it is possible to facilitate entry to a person's property without use of force.

Mentally disordered people found in public places

- 13.11** Removal to a place of safety may take place if the police officer believes it necessary in the interests of that person, or for the protection of others.
- 13.12** Article 36 allows for the removal to a place of safety of any person found in any place other than a private dwelling who appears to a police officer to be suffering from mental disorder and to be in immediate need of care or control.
- 13.13** A private dwelling is defined as a place to which the public do not normally have access. Public houses, shops, hospitals, hotels, care homes, tents, and communal areas in a block of flats are not to be regarded as private dwellings for this purpose. However, gardens, outhouses, garages and yards which are not communally shared are to be so regarded. Vehicles of any type are not to be regarded as private dwellings unless they are situated on property belonging to the person who is to be assessed.

13.14 If a police officer has legitimately gained entry to a person's home for any other reason other than in relation to concerns relating to a person's mental health, (or if the person has permitted the police officer to enter their home following concerns having been raised), the police officer may convey the person to a place of safety if the person agrees. However, Article 36 cannot be used to take a person from their own home against their wishes. In such instances the police may remain with the person and support the assessing team in undertaking an assessment in the person's own home. It would not normally be necessary to source an Article 35 warrant if access to the person's home can already be facilitated with the person's agreement. However, in the event that the person requests that the police leave their home prior to an assessment having been completed, there are no powers to remain without permission and consequently a warrant would most likely be required.

13.15 The purpose of removing a person to a place of safety is only to enable the person to be examined by a doctor and interviewed by an AO, so that necessary arrangements can be made for the person's care and treatment. Detention to a place of safety must culminate in a Mental Health Law assessment. The person cannot be discharged from Article 36 until this has taken place.

13.16 The maximum period a person may be detained under Article 36 is 72 hours. The imposition of consecutive periods of detention is unlawful. It is not anticipated that the Article be permitted to stay in situ for the entire 72 hours. Although there may be occasions when this becomes necessary on account of intoxication or aggressive behaviour, it will normally be the case that an assessment will take place within a short period following the person's detention to a place of safety.

Protocol on the use of police powers and places of safety

13.17 It is important to ensure that a jointly agreed protocol is in place governing all aspects of the use of Articles 35 and 36. Good practice depends on a number of factors. For example:

- the Department, Approved Establishments, the police and other relevant emergency services should ensure that they have a joint protocol in place for the use of powers under Articles 35 and 36, as well as the operation of the agreed places of safety
- all professionals involved in implementation of the powers should understand them and their purpose, and the roles and responsibilities of other people involved, and should follow the protocol
- professionals involved in implementation of the powers should receive specific training, and
- the parties to the protocol should meet regularly to discuss its effectiveness in the light of experience.

13.18 The protocol will define responsibilities for:

- providing secure places of safety in healthcare settings
- identifying and agreeing the most appropriate place of safety in individual cases
- providing prompt assessment and, where appropriate, admission to an Approved Establishment for further assessment or treatment
- securing the attendance of police officers, where appropriate for the patient's health or safety or for the protection of others
- the safe, timely and appropriate conveyance of the person to and between places of safety (bearing in mind that hospital or ambulance transport will generally be preferable to police transport, which should be used exceptionally, such as in cases of extreme urgency or where there is a risk of violence)
- deciding whether it is appropriate to transfer the person from the place of safety to which they have been taken to another place of safety
- dealing with people who are also under the effects of alcohol or drugs
- dealing with people who are behaving, or have behaved, violently
- arranging access to a hospital accident and emergency department for assessment, where necessary
- monitoring and audit of practice against protocol, and
- the release, transport and follow-up of people assessed under Article 35 or 36 who are not then admitted to an Approved Establishment or immediately accommodated elsewhere.

13.19 Responsibilities should be allocated to those who are best able to carry them out, bearing in mind the different purposes for which the Department and the police exist. The protocol should ensure that police know whom to contact whilst implementing the removal of a person to a place of safety under Article 36.

Assessment at a place of safety

13.20 The same care should be taken in examining and interviewing people in places of safety as in any other assessment. No assumptions should be made about them simply because the police have been involved, nor should they be assumed to be in any less need of support and assistance during the assessment. The guidance on assessment in Chapter 5 applies in these circumstances as in any others.

- 13.21** Once Article 36 is utilised and the person arrives at the place of safety, a Mental Health Law assessment must take place as soon as is reasonably practicable.
- 13.22** The authority to detain a person under Articles 35 and 36 ends as soon as it has been decided, following a Mental Health Law assessment, to make no application in respect of them under Part 3 of the Law. At this time, the person can no longer be detained under the Law.

Record keeping

- 13.23** A record of the person's time of arrival must be made immediately when they reach the place of safety. As soon as detention in a place of safety under Article 35 or 36 ends, the individual must be told that they are free to leave by those who are detaining them. The organisation responsible for the place of safety should ensure that proper records are kept of the time of the person's detention under these Articles.
- 13.24** Given that the maximum period of detention at a place of safety is not affected by any subsequent transfer to a different place of safety, it is very important to ensure that the time of detention at the first place of safety is recorded clearly. In the event of a transfer, this information should be shared between the transferring and receiving place of safety.

Monitoring the use of the Law

- 13.25** The locally agreed protocol should include arrangements for the use of Article 36 to be monitored effectively so that:

- a check can be made of how, in what circumstances and with what outcome it is being used, including its use in relation to people from minority communities and children and young people; and
- the parties to the protocol can consider any changes to the mental health services or police operations, or any other matters that might result in a reduction of its use.

- 13.26** The local protocol should address who is responsible for collecting, analysing and disseminating the information required for monitoring purposes. It should also set targets for assessment at a place of safety, and the relevant parties should review practice against these targets.
- 13.27** The data and information utilised in monitoring the use of the Law must be shared with The Administrator. This will in turn be shared with the Minister and may be included in the annual report prepared by the Administrator.

Rights of persons detained in places of safety

- 13.28** A person removed under Article 35 or 36 is deemed to be detained for the purposes of the Police Procedures and Criminal Evidence (Jersey) Law 2003 (PPACE). This means that police officers have the power to search a person they detain under Article 35 or 36 of the Law, as they would in the case of a person arrested for an offence. If a person is taken to the police station, under Article 50 of PPACE, the custody officer has the power to ascertain what items the person has on them, to remove items (where permitted) and to search the person as necessary for those purposes.
- 13.29** Where an Approved Establishment is used as a place of safety, the Department must ensure that the provisions of Article 78 of the Law (giving of information), are complied with. In addition, access to legal advice should be facilitated whenever it is requested.
- 13.30** If a person is detained in the police station as a place of safety, they have a right of access to legal advice under PPACE. The conditions of detention and treatment of the person must be in accordance with PPACE Code of Practice. Among other things, this requires that the person must be notified of their rights and entitlements, both orally and in writing. This will be achieved by handing the person a copy of the Notice of Rights and Entitlements.
- 13.31** In all cases the person detained should be told that the maximum period of detention is 72 hours.

13

Place of safety and consent to treatment

- 13.32** Detaining a patient in a place of safety under Article 35 or 36 does not confer any power under the Law to treat them without their consent. In other words, they are in exactly the same position in respect of consent to treatment as patients who are not detained under the Law.

Making necessary arrangements following assessment

- 13.33** Once the assessment has been concluded, it is the responsibility of the doctors and the AO involved to make any necessary further arrangements for the person's care and treatment. It is usually appropriate for these arrangements to be made as soon as possible.
- 13.34** It should also be borne in mind that a person who is removed to a place of safety may already be on leave of absence from detention in an Approved Establishment and that his recall to an Approved Establishment may need to be considered. If it becomes apparent that this is the case, the professionals assessing the patient should make an effort to contact the person's AP as soon as possible.
- 13.35** Where the person is known to be on Article 24 Leave and compulsory admission is indicated, the recall power should be used.



Chapter 14: Conveyance of patients

Chapter 14

General considerations	107
Transporting to hospital on the basis of an application for detention.....	108
Locally agreed arrangements	110
Transporting patients between Approved Establishments and returning patients who abscond.....	111
Transporting patients on leave or indefinite leave who are recalled to hospital.....	111

Chapter 14: Conveyance of patients

- 14.1** Article 20 of the law gives authority for the conveyance of a patient when they meet the requirements for admittance.
- 14.2** Patients may need to be transported between different locations. This Chapter provides information about how patients should be conveyed in a manner that is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people, and the factors that should be taken into account.
- 14.3** Agencies, including the police, ambulance service and the Department should agree joint local policies to ensure that patients can be conveyed without delay. When transport between hospitals is required, Approved Establishment managers should make appropriate arrangements. Guidance is provided on transporting patients to hospital on the basis of an application for detention, transporting patients who abscond and transporting patients who are subject to a leave of absence or indefinite leave who are recalled to hospital.

14

General considerations

- 14.4** Patients should always be transported in the manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people. Where a patient may lack capacity, professionals should have regard to the principles and provisions of the Capacity Law.
- 14.5** This applies in all cases where patients are compulsorily transported under the Law, including:

- taking patients to hospital to be detained for assessment or treatment
- transferring patients between Approved Establishments
- returning patients to hospital if they are absent without leave
- taking patients who have leave of absence but have been recalled, back to hospital
- taking and returning patients who are subject to Guardianship to the place in which their Guardian requires them to live

- taking patients to, and between, places of safety, and
- taking patients to and from court.

14.6 When deciding on the most appropriate method for transporting a patient, factors to be taken into account include:

- the availability of different transport options
- the wishes and views of the patient, including any relevant statement of those views or wishes made in advance
- any physical disability the patient has
- any risks to the health and safety of the patient – including their need for support, supervision and clinical care or monitoring during the journey. This is particularly important where sedation has been, or may be used
- the nature of the patient’s mental disorder and their current state of mind
- the likelihood of the patient behaving in a violent or dangerous manner
- the health and safety of the people transporting the patient and anyone else accompanying them
- the likelihood that the patient may attempt to abscond and the risk of harm to the patient or other people were that to happen.

Transporting to hospital on the basis of an application for detention

14.7 Patients who have been sedated before being transported should always be accompanied by a health professional who is knowledgeable in the care of such patients, is able to monitor the patient closely, identify and respond to any physical distress which may occur and has access to the necessary emergency equipment to do so.

14.8 A properly completed application for detention under the Law, together with the required medical recommendations, gives the applicant (the AO) the authority to transport the patient to the hospital named in the application.

14.9 Where an application has been made by an AO, the AO has a professional responsibility to ensure that all the necessary arrangements are made for the patient to be transported to hospital. All relevant agencies should actively support the AO in order to ensure safe transport to hospital.

- 14.10** AOs should make decisions on which method of transport to use in consultation with the other professionals involved, the patient and (as appropriate) their carer. The decision should be made following a risk assessment carried out on the basis of the best available information.
- 14.11** If the patient is unwilling to be moved, the AO will need to provide the people who are to transport the patient (including any ambulance staff or police officers involved), with the authority to transport the patient.
- 14.12** That detention papers have been received and an application for admission duly made provides the authority for conveyance to the AO. The AO may then delegate this responsibility to other agencies such as the police or ambulance service. This will give them the legal power to transport patients against their will, using reasonable force if necessary, and to prevent them absconding en route.
- 14.13** There is no requirement for agencies such as the police or ambulance service to accept this delegated authority. However, if delegated authority is not accepted, all agencies involved in the decision around how to convey the patient must formulate and agree a safe and appropriate plan as to how to manage the situation.
- 14.14** The Article papers must be provided to the staff member who receives the patient at the Approved Establishment. Normally they will travel with the patient but may be taken separately as the situation requires.
- 14.15** If the patient's behaviour is likely to be violent or dangerous, the police should be asked to assist in accordance with locally agreed arrangements. Where practicable, given the risk involved, an ambulance should be used even where the police are assisting. In the event that the patient presents too high a risk to travel in the ambulance, the police may convey the patient to the Approved Establishment directly.
- 14.16** The locally agreed arrangements should set out what assistance the police will provide in transporting patients safely, and what support ambulance or other health services will be expected to provide where patients are, exceptionally, transported in police vehicles.
- 14.17** Where it is necessary to use a police vehicle because of the risk involved, it may be necessary for a member of an ambulance crew to ride in the same vehicle with the patient, with the appropriate equipment to deal with immediate problems. In such cases, the ambulance should follow directly behind to provide any further support that is required.
- 14.18** AOs should only agree to a patient being transported by private vehicle only if they are satisfied that the patient and others will be safe from risk of harm and that it is the most appropriate way of transporting the person. In general this is to be avoided.

14.19 People authorised by the applicant to transport patients act in their own right and not as the agent of the applicant. They may act on their own initiative to restrain patients and prevent them absconding, if absolutely necessary. AOs retain a professional responsibility to ensure that the patient is transported in a lawful and humane manner and should give guidance to those asked to assist.

14.20 Patients may be accompanied by another person, provided that the AO and the person in charge of the vehicle are satisfied that this will not increase the risk of harm to the patient or others.

14.21 Before patients are moved, the applicant should ensure that the receiving hospital is expecting the patient and has been told the likely time of arrival. If possible, the name of the person who will be formally receiving the patient and their Article papers should be obtained in advance.

14 Locally agreed arrangements

14.22 The respective responsibilities of different agencies and service providers for transporting patients in different circumstances should be clearly established locally and communicated to the professionals who need to know.

14.23 In particular, it is essential to have clear agreements in place so that people who need assistance in transporting patients under the Law can obtain it without delay. Agencies, including the Department, ambulance and transport services and the police, should agree joint local policies and procedures. These should include:

- a clear statement of the respective roles and obligations of each agency and service provider (and their staff)
- the assistance that managers and staff of hospitals will provide to AOs to make necessary arrangements for the transport of patients who are to be admitted to their hospital
- guidance and training (including refresher training) on legal powers in relation to transporting patients
- a clear statement of how risk assessment and management should be conducted and how the outcomes will influence decisions in relation to the transport of patients
- agreement on the appropriate use of different methods of restraint in transporting patients and how decisions on their use will be made in any given case

- any special arrangements where patients need to be transported outside of Jersey, and
- processes for reviewing and monitoring the involvement of the different agencies, including standards against which delivery will be monitored.

14.24 Policies and procedure should also be consistent with those agreed in relation to the use of the police powers in Articles 35 and 36 of the Law.

Transporting patients between Approved Establishments and returning patients who abscond

14.25 Where a patient requires transport between Approved Establishments, it is for the managers of the establishments concerned to make sure that appropriate arrangements are put in place. The managers of the establishment from which the patient is being transferred remain responsible for the patient until the patient is admitted to the new establishment.

14.26 Where a patient who is absent without leave from an Approved Establishment is taken into custody by someone working for another agency, the managers of the Approved Establishment from which the patient is absent are responsible for making sure that any necessary transport arrangements are put in place for the patient's return.

14.27 The agency which temporarily has custody of the patient is responsible for them in the interim and should assist in ensuring that the patient is returned in a timely and safe manner.

14.28 When making arrangements for the return of patients temporarily held in police custody, managers of Approved Establishments should bear in mind that police transport to return them to the Approved Establishment will not normally be appropriate. Decisions about the kind of transport to be used should be taken in the same way as for patients being detained for the first time.

Transporting patients on leave or indefinite leave who are recalled to hospital

14.29 A notice of recall, properly completed by an AP (either the patient's own RMO or another psychiatrist to whom responsibility for recall of the patient has been delegated), and served to the patient, provides the authority to transport a patient on leave to hospital.

- 14.30** The AP has responsibility for co-ordinating the recall process. The factors outlined above and the urgency of the situation, will need to be considered in deciding the best way to transport the patient to hospital. The guidance above in relation to taking patients to hospital when they are first to be detained applies here as well, except that there is no role for either an AO or a second doctor.
- 14.31** A patient on leave who has been recalled can be transported by any appropriate staff member of the Approved Establishment to which the patient is recalled, any police officer, any AO or any other person authorised in writing by the AP or the managers of that Approved Establishment. The identity of the most appropriate person to transport the patient will depend on the individual circumstances.



Chapter 15: Holding powers

Chapter 15

Approved practitioner holding powers under Article 15	114
Ending holding powers under Article 15	115
Authorised nurses holding powers under Article 17	115
Assessment before invoking Article 17	116
Action to be taken once Article 17 powers are used.....	117
General points about using Article 15 and Article 17	117
Recording the end of detention	117
Monitoring use.....	118
Information.....	118
Medical treatment of patients	118
Transfer to other Approved Establishments	118

Chapter 15: Holding powers

- 15.1** This Chapter gives guidance on the use of holding powers available to AP's under Articles 15 and nurses under Article 17 in respect of relevant patients. In terms of an AP, a relevant patient means a patient who is brought to or presents at an Approved Establishment or has been admitted to or remains in an Approved Establishment under or in accordance with Article 14.
- 15.2** In regards to detention by a nurse, a relevant patient is one that is receiving treatment for mental disorder as an in-patient in an Approved Establishment or remains in an Approved Establishment under or in accordance with Article 14. Therefore, Article 17 can only be exercised in relation to patients who have been voluntarily admitted to an Approved Establishment or to a hospital for treatment of their mental disorder.

15

Approved practitioner holding powers under Article 15

- 15.3** Article 15 can be used where an AP who is treating a relevant patient concludes that an application for detention to an Approved Establishment under the Law should be made. It authorises the detention of a patient in an Approved Establishment for a maximum of 72 hours so that the patient can be assessed with a view to such an application being made. It cannot be renewed immediately upon expiry.
- 15.4** An AP who is treating a relevant patient need not be the RMO responsible for the treatment of that patient.
- 15.5** The period of detention starts at the moment that the designated form is signed. The original document must be provided to The Administrator and a copy held on the ward.
- 15.6** Article 15 should only be used if, at the time, it is not practicable or safe to take the steps necessary to make an application for detention without detaining the patient in the interim. In particular it should be used in the event that a patient expresses a wish to leave the ward and there are concerns for the patient's safety and/or health and/or the safety of others were this to take place.
- 15.7** AP's should use the power only after having personally examined the patient.

Ending holding powers under Article 15

15.8 Although the holding power lasts for a maximum of 72 hours, it should not be used to continue to detain patients after:

- the doctor decides that, in fact, no assessment for a possible application needs to be carried out, or
- a decision is taken not to make an application for the patient's detention.

15.9 Patients should be informed immediately that they are no longer detained under the holding power and are free to leave the hospital if they wish to, even if they have agreed to continue to remain informally.

Authorised nurses holding powers under Article 17

15.10 The power can be used where an authorised nurse who is in charge of or responsible for, the treatment of a relevant patient concludes that the patient is suffering from a mental disorder to such a degree that the patient needs to be detained for their own health or safety or to protect others from harm. Such powers should only be used in situations where there is immediate risk and an AP cannot attend immediately. It authorises the detention of a patient at the place where he is receiving treatment for a maximum of 6 hours.

15.11 The purpose of Article 17 is to allow for the temporary detention of a patient who is receiving treatment for mental disorder as an in-patient in an Approved Establishment. It is not permissible that Article 17 be used to facilitate the temporary detention of a patient receiving treatment for a physical disorder even if the physical disorder is in some way associated with a mental disorder. Resultantly, Article 17 ought not to be applied in a general hospital ward.

15.12 The use of the holding power permits the patient's detention for up to 6 hours or until an AP arrives. It cannot be renewed.

15.13 In the event that an AP arrives within the final hour of the 6 hour detention, the Article 17 detention may be extended for a maximum of 1 hour. The AP may then determine to use an Article 15 detention if a Mental Health Law assessment is not yet completed. However, the combined effect of both Articles cannot exceed 72 hours.

15.14 The patient may be detained from the moment the nurse signs the designated form. The original must be provided to The Administrator and a copy held on the ward.

15.15 The decision to invoke the power is the professional decision of the nurse, who cannot be instructed to exercise the power by anyone else, or delegate it to someone else.

Assessment before invoking Article 17

15.16 Before using the power, nurses should assess the likely arrival time of the AP against the likely intention of the patient to leave and the consequences of a patient leaving the hospital before the AP arrives i.e. the harm that might occur to the patient or others. It may be possible to convince the patient to wait until the AP arrives to discuss the matter further.

15.17 In doing so, nurses should consider:

- the patient's expressed intentions
- the likelihood of the patient harming themselves or others
- the likelihood of the patient behaving violently
- any evidence of disordered thinking
- the patient's current behaviour and, in particular, any changes in their usual behaviour
- whether the patient has recently received messages from relatives or friends
- whether the date is one of special significance for the patient (e.g. the anniversary of a bereavement)
- any recent disturbances on the ward
- any relevant involvement of other patients
- any history of unpredictability or impulsiveness
- any formal risk assessments which have been undertaken (specifically looking at previous behaviour), and
- any other relevant information from other members of the multi-disciplinary team.

15.18 Nurses should be particularly alert to cases where patients suddenly decide to leave or become determined to do so urgently.

15.19 Nurses should make as full an assessment as possible in the circumstances before using the power but sometimes it may be necessary to invoke the power on the basis of only a brief assessment.

Action to be taken once Article 17 powers are used

- 15.20** The reasons for invoking the power should be entered in the patient's notes. Details of any patients who remain subject to the power at the time of a shift change should be given to staff coming on duty.
- 15.21** The use of Article 17 is an emergency measure and the AP with the power to use Article 15 in respect of the patient should treat it as such and arrive as soon as possible. The doctor should not wait 6 hours before attending simply because this is the maximum time allowed.
- 15.22** However, if the AP then uses their own holding power, the maximum period of 72 hours should be calculated from when the nurse first made the record detaining the patient under Article 17.
- 15.23** If no AP who is able to make a report under Article 15 has attended within 6 hours, the patient may not be detained for any longer and may leave if not prepared to stay voluntarily. This should be considered as a serious failing, and should be reported and investigated as such. If there are genuine concerns relating to the safety of the patient or to the public, the police must be made aware of all relevant details pertaining to the patient and the manager must be alerted.

15

General points about using Article 15 and Article 17

- 15.24** The data and information utilised in monitoring the use of Articles 15 and 17, as detailed below, must be shared with The Administrator. This will in turn be shared with the Minister and may be included in the annual report.

Recording the end of detention

- 15.25** The time at which a patient ceases to be detained under either Article should be recorded, preferably using a standardised system. The reason why the patient is no longer detained under the power should be recorded, as well as what then happened to the patient (e.g. the patient remained in an Approved Establishment voluntarily, was discharged, or was detained under a different power).
- 15.26** Detention under Article 15 or 17 cannot be renewed immediately but that does not prevent it from being used again on a future occasion if necessary.

Monitoring use

15.27 The Approved Establishment must monitor the use of these Articles including:

- how quickly patients are assessed for detention and discharged from the holding power
- the attendance times of doctors following the use of Article 17, and
- the proportion of cases in which applications for detention are made following the use of Article 15 or Article 17.

Information

15.28 The AP must ensure that patients detained under Article 15 or Article 17 are given information about their position and their rights, as required by Article 78 of the Law. This must be detailed on the patient's record in order that compliance with the Law can be audited.

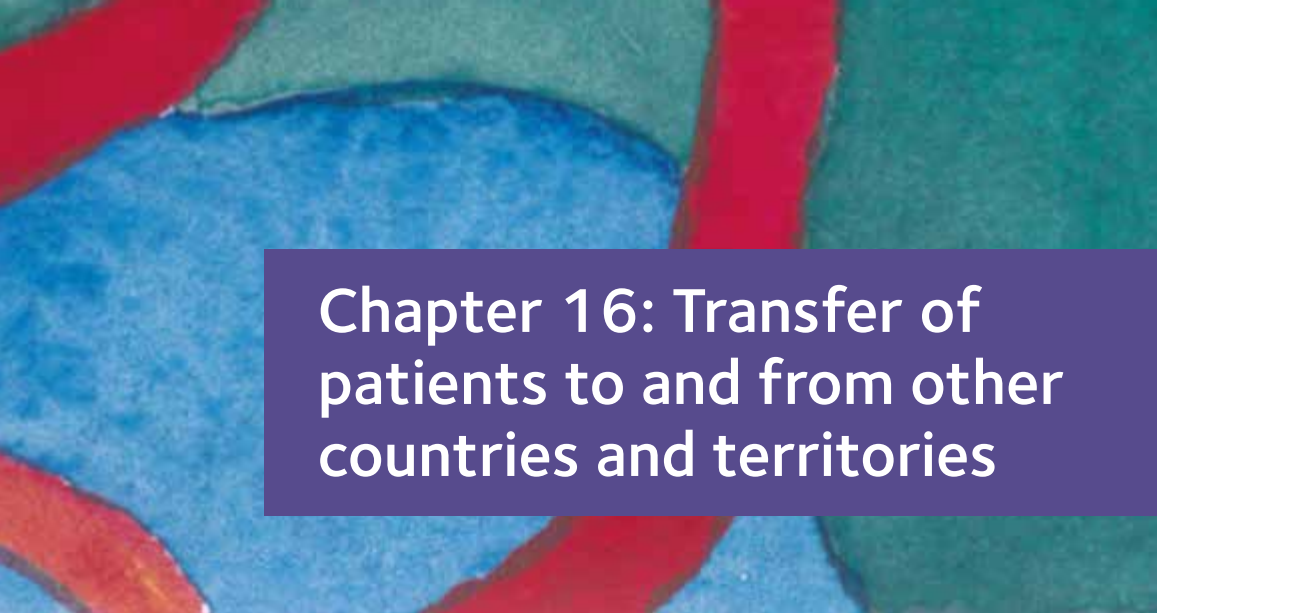
15

Medical treatment of patients

15.29 Detaining patients under Article 15 or Article 17 does not confer any power under the Law to treat them without their consent. That is to say, they are in exactly the same position in respect of consent to treatment as patients who are not detained under the Law.

Transfer to other Approved Establishments

15.30 It is possible for patients detained under Article 15 or Article 17 to be transferred to another Approved Establishment under Article 26 if circumstances dictate that this is necessary. However, wherever possible a Mental Health Law assessment should be undertaken prior to such a transfer taking place. The rationale for such a transfer must be clearly recorded in the patient record.



Chapter 16: Transfer of patients to and from other countries and territories

Chapter 16: Transfer of patients to and from other countries and territories

- 16.1** Article 85 to 88 of the Law allows for the removal of a patient to a country or territory outside of Jersey if they are subject to a treatment authorisation, a hospital treatment authorisation or a remand order under Article 61, 62 or 63.
- 16.2** An application and a letter detailing the receiving hospital and RMO is made to the Minister, who if satisfied that the criteria for the transfer are met, may grant an overseas transfer order, and give any necessary directions for the patient's conveyance to their destination.
- 16.3** Article 89 of the Law allows for the transfer of patients outside of Jersey to Jersey from another country or territory under a provision of any law that corresponds to Article 86, and who immediately before the patient's transfer was liable to be detained in that country or territory under a provision corresponding to any provision of this Law.
- 16.4** When a transferred patient is admitted to an Approved Establishment, on the date that the patient is admitted the patient shall be treated as if they had been admitted in pursuance of an order under the provisions of this Law corresponding to the provisions of the law from the country or territory from which the patient was transferred.

The effect of this is that a patient who had been admitted in a different jurisdiction under a corresponding Article or Section of an Act or Law for assessment will be detained in Jersey according to Article 21. Equally, a patient who had been admitted in a different jurisdiction under a corresponding Article or Section of an Act or Law for treatment will be detained in Jersey according to Article 22. The period of detention must take into account any time already spent in the previous jurisdiction. For example, if a patient had been detained for a three month period (of a six month treatment authorisation) in the previous authority, the patient will only be liable for detention for a further three months upon arrival into Jersey.

However, any appeals to a Tribunal which have already occurred in the jurisdiction from which the patient was transferred must not be taken into account in determining the eligibility for a tribunal hearing in Jersey. The patient will therefore be entitled to apply for tribunal hearing upon arriving into Jersey.

- 16.5** It is acknowledged that the Code provides limited guidance in respect of transfers. However, it is a requirement that a multi-agency protocol in respect of transfers to and from other jurisdictions is developed. This should be adhered to when such transfers are to be undertaken.

Chapter 17: Capacity and significant restriction on liberty

Chapter 17

Definitions and principles.....	123
Capacity and significant restriction on liberty.....	123
Defining 'lack of capacity'.....	125
Care planning.....	126
Acts that can be undertaken under the Capacity Law.....	127
Treatment for physical conditions (where the individual is liable to be detained under the Law).....	128
Authorising Significant Restrictions on Liberty.....	128
Determining between SRoL and the Law.....	129
Electro-convulsive therapy (ECT).....	131

Chapter 17: Capacity and significant restriction on liberty

- 17.1** A sound understanding and application of the principles and provisions of the Capacity Law is essential to enable decision makers to fulfil their legal responsibilities and to safeguard their patients' rights under the Convention. For the purposes of this Chapter, the Mental Health (Jersey) Law will continue to be referred to as 'the Law'.
- 17.2** Practitioners should be able to identify the legal framework that governs a patient's assessment and treatment and authorise any appropriate significant restriction on a patient's liberty. This may be either the Capacity Law and/or the Law. The legal framework is not static and may change as the patient's circumstances and needs change.

Definitions and principles

17

17.3 Definitions for the purposes of this Chapter:

Significant restriction on liberty authorisations (SRoL) – the framework of safeguards under the Capacity Law for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves. Such restrictions must be the least restrictive in order to achieve the required outcome.

17.4 Age and applicability:

- the Capacity Law, in general, applies to individuals aged 16 years and over
- a person must be 16 to make an Advance Decision to Refuse Treatment but must be 18 in order to create a Lasting Power of Attorney (LPA) under the Capacity Law.

Capacity and significant restriction on liberty

- 17.5** The Capacity Law empowers individuals to make their own decisions where possible and protects the rights of those who lack capacity. Where an individual lacks capacity to make a specific decision at a particular time, the Capacity Law provides a legal framework for others to act and make that decision on their behalf, in their best interests, including where the decision is about care and/or treatment.

- 17.6** The Capacity Law places a strong emphasis on the need to support individuals to make their own decisions. Information should be explained in a manner best suited to the individual to aid the individual's understanding. All individuals should be encouraged to participate in decision making and professionals should carefully consider the individual's wishes at all times.
- 17.7** The Capacity Law should be central to the approach professionals take in respect of patients who lack capacity in all health and care settings (including psychiatric and general hospitals). The starting point should always be that the Capacity Law should be applied wherever possible to individuals who lack capacity and are detained under the Law (but see 17.8).
- 17.8** In some situations, the provision of treatment under the Law will limit the operation of aspects of the Capacity Law. For example, if a patient's treatment is being regulated by Part 3 of the Law, then the Capacity Law cannot in general be used to authorise medical treatment for mental disorder. For such a patient, any Advance Decision to Refuse Treatment (ADRT) relating to the refusal of a proposed medical treatment for mental disorder or any decision taken by their Attorney or Delegate under the Capacity Law to refuse consent to proposed medical treatment, cannot prevent medical treatment for mental disorder being given under Part 3 of the Law.
- 17.9** An exception to this is electro-convulsive therapy (ECT). A person who has made a valid and applicable advance decision under the Capacity Law, or for whom a decision has been taken by their Attorney or Delegate, to refuse ECT would mean that ECT could not be provided except in an emergency situation.
- 17.10** At the heart of the Capacity Law are five statutory principles:

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

- 17.11** It is important for professionals to be aware that individuals with a mental disorder, including those liable to be detained under the Law, do not necessarily lack capacity. The assumption should always be that a patient subject to the Law has capacity, unless it is established otherwise in accordance with the Capacity Law.
- 17.12** Healthcare providers have a legal duty to care for and treat patients who lack capacity in accordance with the Capacity Law, when it applies.

Defining 'lack of capacity'

- 17.13** A person lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of their mind or brain.
- 17.14** The above definition contains both 'functional' and a diagnostic' elements.

The functional element determines whether the individual is unable to make a specific decision.

The diagnostic element determines whether the individual has an impairment of, or a disturbance in the functioning of, the mind or brain. The impairment or disturbance can be temporary or permanent, but if it is temporary, the decision-maker should justify why the decision cannot wait until the circumstances change.

The two elements are linked by a third element in that an inability to make a decision must be because of the impairment or disturbance, as opposed to some other cause.

All three elements form part of the capacity assessment. Each element must be satisfied for an individual to be deemed to lack capacity to make the specific decision in question at the material time.

- 17.15** A person is 'unable to make a decision' for themselves if they are unable to do any one of the following:

- understand information which is relevant to the decision to be made
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision (whether by talking, sign language or any other means).

- 17.16** As capacity relates to specific matters and can change over time, capacity should be reassessed as appropriate over time and in respect of specific treatment decisions. Decision makers should note that the Capacity Law test of capacity should be used whenever assessing a patient's capacity to consent for the purposes of the Law.

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

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

Care planning

17.18 The five statutory principles of the Capacity Law form a vital part of developing a patient's care plan and should be integral to this process.

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

17.20 Care planning, including planning for discharge, must adhere to the steps for determining what is in the person's best interests. This ensures participation by the person and consideration of their wishes, feelings, beliefs and values and consultation with specified others (e.g. carers, Attorneys, Delegates and people nominated by the person), about the person's best interests.

It is important to recognise that Attorneys and Delegates are legal decision-makers whereas carers and others nominated by the person are not. It is therefore important to refer to the Capacity Law and its associated Code of Practice in respect of the role, function and powers of Attorneys and Delegates.

Acts that can be undertaken under the Capacity Law

- 17.21** The Capacity Law recognises that situations will occur when carers, healthcare and social care staff will need to make decisions on behalf of individuals who lack capacity to make particular decisions themselves (including decisions that relate to care and/or treatment for mental and/or physical conditions).
- 17.22** The Capacity Law can be relied upon to treat mental disorder where the patient lacks capacity to make the decision in question and such treatment is in the patient's best interests, provided that the treatment is not regulated by Part 3 of the Law.
- 17.23** The Law does not regulate the treatment of physical conditions that are unrelated to mental disorders.
- 17.24** The Capacity Law provides protection from legal liability for certain acts of restraint – provided those acts are reasonably believed to be in the best interests of the individual. In this context restraint means using or intending to use force to make a person do something they are resisting, or may resist, or restricting the person's liberty of movement, whether or not the person resists.
- 17.25** In considering the use of restraint, decision-makers should carefully take into account the need to respect an individual's liberty and autonomy. Article 9 of the Capacity Law states that, in addition to needing to be in the best interests of the person who lacks capacity in respect of the relevant decision, acts of restraint will only be permitted if:
- the person taking action reasonably believes that restraint is necessary to prevent harm to the person who lacks capacity, and
 - the restraint is a proportionate response to the likelihood and seriousness of that harm.
- 17.26** Article 9 of the Capacity Law cannot be relied on if the overall care package, including any proposed measures of restraint and/or proposed restrictions on movement, will give rise to a 'significant restriction on liberty'. A significant restriction on liberty will engage Article 5 of the Convention and must be specifically authorised under the Capacity Law by a significant restriction on liberty (SRoL) authorisation, court order or otherwise made lawful by way of detention under the Law.
- 17.27** It is important to note that if a potential significant restriction on liberty is identified, the first step should always be to review the care plan to see if a less restrictive approach could be taken that would prevent that significant restriction on liberty from arising.

Treatment for physical conditions (where the individual is liable to be detained under the Law)

- 17.28** The Law regulates medical treatment of mental disorder for individuals who are liable to be detained under the Law. This may include treatment of physical conditions that is intended to alleviate or prevent a worsening of symptoms or a manifestation of the mental disorder (e.g. a clozapine blood test) or where the treatment is otherwise part of, or ancillary to, treatment for mental disorder.
- 17.29** Where individuals liable to be detained under the Law have a physical condition unrelated to their mental disorder, consent to treat this physical condition must be sought from the individual. If the individual does not have the capacity to consent, treatment can be provided under the Capacity Law as long as it is in their best interests. This will need to be documented in the appropriate format.
- 17.30** If the individual is subject to a significant restriction on their liberty and the need for physical treatment is the only reason why the person needs to be detained in hospital, then the patient is not within the scope of the Law (as the purpose of the significant restriction on liberty is not to treat mental disorder) and an SRoL authorisation or a decision of court should be sought.

17

Authorising Significant Restrictions on Liberty

- 17.31** The processes relating to SRoL forms part of the Capacity Law and as such are borne out of the Capacity Law's five statutory principles. SRoL only apply to individuals who lack the capacity to consent to accommodation in an Approved Establishment where care and/or treatment provided in that accommodation amounts (or is likely to amount) to a significant restriction on liberty.
- 17.32** An SRoL authorisation does not in itself authorise care or treatment, only the significant restriction on liberty that results from the implementation of the proposed care plan. Any necessary care or treatment should be provided in accordance with the Capacity Law.
- 17.33** When considering whether to apply for an SRoL authorisation, decision-makers should first assess the capacity of the person to consent to the arrangements for their care or treatment, in accordance with the Capacity Law.
- 17.34** Next, decision-makers should consider whether the circumstances of the proposed accommodation and treatment amount (or are likely to amount) to a significant restriction on liberty. Consideration must also be given at this stage to whether the patient's care plan can be amended to avoid any potential significant restriction on liberty.

- 17.35** The term *significant restriction on liberty* cannot be precisely defined and requires carefully considered judgement on the part of the assessor. A significant restriction on liberty is more likely to be evident where a person is under continuous control and supervision, is not free to leave and lacks capacity to consent to these arrangements.
- 17.36** Particular factors are not relevant when determining whether there is a significant restriction on liberty. These include the person's compliance or lack of objection and the reason or purpose behind a particular placement. The relative normality of the placement (whatever the comparison made) is also not relevant.
- 17.37** The definition of a significant restriction on liberty may develop over time in accordance with developments in UK and European case-law. In order for decision-makers to be able to assess whether the situation they are faced with constitutes (or is likely to constitute) a significant restriction on liberty, they should keep abreast of the latest case law developments.

Determining between SRoL and the Law

17.38 If an individual:

- a. is suffering from a mental disorder (within the meaning of the Law)
- b. needs to be assessed and/or treated in an Approved Establishment (including a hospital) for that disorder or for physical conditions related to that disorder (and meets the criteria for an application for admission under Articles 21 or 22 of the Law)
- c. is being or is likely to be subject to a significant restriction on liberty
- d. lacks capacity to consent to being accommodated in the Approved Establishment for the purpose of treatment, and
- e. does not object to being admitted to the Approved Establishment, or to some or all the treatment they will receive there for mental disorder.

Then in principle an SRoL authorisation (or potentially a court order) and detention under the Law would both be available (subject to the outcome of associated assessments). This is the one situation where the option of using either the Law or SRoL exists. It is important to note that a person cannot be detained under the Law at the same time as being subject to a SRoL authorisation or a court order.

However, a patient could be subject to an SRoL authorisation whilst in receipt of leave or indefinite leave from hospital in the event that they were, for example, discharged from hospital to a care home. It is crucial that the conditions attached to leave do not in themselves constitute a significant restriction on a person's liberty. A significant restriction can only be authorised by either an SRoL authorisation or by the authority of the court.

- 17.39** Whether a patient is objecting has to be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. The decision to be made is whether the patient objects; the reasonableness of that objection is not the issue. In many cases the patient will be perfectly able to state their objection. In other cases the professional undertaking an assessment of whether an SRoL is warranted will need to consider the patient's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained. In deciding whether a patient objects to being admitted to hospital, or to some or all of the treatment they will receive there for mental disorder, decision-makers should err on the side of caution.
- 17.40** A person who lacks capacity to consent to being accommodated in a hospital for care and/or treatment for mental disorder and who is likely to be made subject to a significant restriction on their liberty should never be informally admitted to hospital (whether they are content to be admitted or not).
- 17.41** Decision-makers should also consider whether an individual whose liberty is being significantly restricted may regain capacity or may have fluctuating capacity. Such a situation is likely to indicate whether use of the Capacity Law in order to authorise a significant restriction on liberty is appropriate.
- 17.42** In an emergency situation, a significant restriction on an individual's liberty for the purpose of life-sustaining treatment or doing any vital act while a decision is sought from the court can be undertaken prior to such a decision being obtained.
- 17.43** For those individuals where both detention under the Law and an SRoL authorisation are available, decision-makers should determine which regime is the more appropriate.
- 17.44** The choice of legal regime should never be based on a general preference for one regime or the other, or because one is more familiar to the decision-maker than the other. In addition decision-makers should not proceed on the basis that one regime is generally less restrictive than the other. Both regimes are based on the need to impose as few restrictions on the liberty and autonomy of patients as possible. In the particular circumstances of an individual case, it may be apparent that one regime is likely to prove less restrictive. If so, this should be balanced against any potential benefits associated with the other.

- 17.45** Both regimes provide appropriate procedural safeguards to ensure the rights of the person concerned are protected during their detention. Decision-makers should not therefore proceed on the basis that one framework generally provides greater safeguards than the other. However, the nature of the safeguards provided under the two frameworks are different and decision-makers will need to exercise their professional judgement in determining which safeguards are more likely to best protect the interests of the patient in the particular circumstances of each individual case.
- 17.46** In the relatively small number of cases where detention under the Law and an SRoL authorisation are available, the Code does not seek to preferentially orientate the decision-maker in any given direction. Such a decision should always be made depending on the unique circumstances of each case. Clearly recording the reasons for the final decision made will be important. The most pressing concern should always be that if an individual lacks capacity to consent to the matter in question and is deprived of their liberty they should receive the safeguards afforded under either the Law or through a SRoL authorisation.


Electro-convulsive therapy (ECT)

- 17.47** ECT cannot be given to an individual who has the capacity to consent to that treatment but refuses to do so unless it is immediately necessary to save the patient's life or to prevent a serious deterioration in the patient's condition.
- 17.48** Under the Law, ECT can only be given to individuals who lack capacity if approved by a second opinion appointed doctor (SOAD).
- 17.49** If ECT is to be given to an individual who lacks capacity and is under a SRoL authorisation, consideration should be given to seeking an independent second medical opinion before treatment which could, in principle, be given under the Capacity Law (remembering that a SRoL authorisation only authorises the significant restriction on liberty, not the treatment).

Section 4: Meeting the needs of specific patients

Why read this section?

In addition to the general guidance provided by the Code, specific groups of patients have additional needs and requirements. The specific groups are people with learning disabilities, people with personality disorders, children and young people under the age of 18 and patients concerned with criminal proceedings. These are addressed in these chapters. The needs of people with autism spectrum disorders are addressed separately in chapter 5.



Chapter 18: People with learning disabilities

Chapter 18

Learning disability.....	135
Abnormally aggressive or seriously irresponsible behaviour.....	136

Chapter 18: People with learning disabilities

18.1 This Chapter deals with issues of particular relevance to patients with learning disabilities.

Learning disability

18.2 For the purposes of the Law, learning disability is defined as, “a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning”.

18.3 Although defined as a mental disorder in this way, learning disability shares few features with serious mental illnesses that are the most common reasons for using the Law. Relatively few people with learning disabilities are detained under the Law and, where they are, it cannot be solely on account of their learning disability.

18.4 The identification of a learning disability is a matter for clinical judgement, guided by current professional practice. Those assessing the patient must be satisfied that they display a number of characteristics. The following is general guidance in relation to the key factors in the definition of learning disability for the purposes of the Law.

Arrested or incomplete development of mind: An individual with arrested or incomplete development of mind is one who has experienced a significant impairment of the normal process of maturation of intellectual and social development that occurs during childhood and adolescence.

This definition embraces the general understanding that features which qualify as a learning disability are present prior to adulthood. For the purposes of the Law, learning disability does not include people whose intellectual disorder derives from accident, injury or illness occurring after they completed normal maturation (although such conditions do fall within the definition of mental disorder in the Law).

Significant impairment of intelligence: The judgement as to the presence of this particular characteristic must be made on the basis of reliable and careful assessment. It is not defined rigidly by the application of an arbitrary cut-off point such as an IQ of 70.

Significant impairment of social functioning: Reliable and recent observations will be helpful in determining the nature and extent of social competence, preferably from a number of sources who have experience of interacting with the person in social situations, including social workers, nurses, speech and language and occupational therapists and psychologists. Social functioning assessment tests can be a valuable tool in determining this aspect of learning disability.

Abnormally aggressive or seriously irresponsible behaviour

18.5 Neither term is defined in the Law and it is not possible to state with any precision exactly what type of conduct could be considered to fall into either category. It will, inevitably, depend not only on the nature of the behaviour and the circumstances in which it is exhibited but also on the extent to which that conduct gives rise to a serious risk to the health or safety of the patient, or to the health or safety of other people, or both.

18.6 In assessing whether a patient's learning disability is associated with conduct that would not only be categorised as aggressive but as abnormally so, relevant factors may include:

- when such aggressive behaviour has been observed, and how persistent and severe it has been
- whether it has occurred without a specific trigger or seems to be out of proportion to the circumstances that triggered it
- whether, and to what degree, it has in fact resulted in harm or distress to other people, or actual damage to property
- how likely, if it has not been observed recently, it is to recur, and
- how common similar behaviour is in the population generally.

18.7 Similarly, in assessing whether a patient's learning disability is associated with conduct that is not only irresponsible but seriously so, relevant factors may include:

- whether behaviour has been observed that suggests a disregard or an inadequate regard for its serious or dangerous consequences;
- how recently such behaviour has been observed and when it has been observed, how persistent it has been;
- how seriously detrimental to the patient, or to other people, the consequences of the behaviour were or might have been;
- whether, and to what degree, the behaviour has actually resulted in harm to the patient or the patient's interests, or in harm to other people or to damage to property; and
- if it has not been observed recently, how likely it is to recur.

- 18.8** Bizarre or unusual behaviour is not the same as abnormally aggressive or seriously irresponsible behaviour.
- 18.9** When assessing whether a patient with a learning disability should be detained for treatment under the Law, it is important to establish whether any abnormally aggressive or seriously irresponsible conduct identified stems from difficulties in communication. If, for example, the patient is displaying such conduct as their only way of drawing attention to an underlying physical health problem, it would be wrong to interpret the behaviour as an indication of a worsening of their mental disorder. In such a case treatment under the Law would not be an appropriate response.
- 18.10** Unless very urgent action is required, it would not be good practice to diagnose a person as having a learning disability associated with abnormally aggressive behaviour or seriously irresponsible conduct (or both) without an assessment by a psychiatrist who is a specialist in learning disabilities. This should form part of a holistic appraisal by medical, nursing, social work, speech and language and occupational therapy and psychology clinicians with experience in learning disabilities, in consultation with a relative, advocate or carer of the person.
- 18.11** All those involved in examining, assessing, treating or taking other decisions in relation to people with learning disabilities should bear in mind that there are particular issues that people with learning disabilities may face. These include:

- incorrect assumptions that they do not have capacity to make decisions for themselves and a tendency to be over-protective;
- over-reliance on family members, both for support and for decision making. Although considerable expertise that family members often have should be acknowledged, this may put them in the difficult position of having to take decisions on behalf of the patient;
- a lack of appreciation of the potential abilities of people with learning disabilities, including their potential to speak up for themselves;
- denial of access to decision-making process, not being included in meetings about them, information being made inaccessible to them, and decisions being made in their absence;
- limited life experiences to draw on when making choices; and
- their learning disability being seen as the explanation for all their physical and behavioural attributes when there may, in fact, be an underlying cause relating to a separate issue of physical or mental health (diagnostic overshadowing).

18.12 People with learning disabilities may encounter problems in:

- understanding what is being explained to them and communicating their views (in situations that increase their levels of anxiety they may find it even more difficult to understand what is said to them); and
- in being understood, particularly where lack of spoken language makes it hard for them to provide explanations of pain or other symptoms that might aid diagnosis of physical or mental illness.

18.13 Where information relates to their right to have their case reviewed by the Tribunal, the information will need to be designed to support people with learning disabilities to understand the Tribunal's role. They may well need support to make an informed decision about whether and when to make an application.

18.14 Where professionals making decisions under the Law have limited expertise with people with learning disabilities, it is good practice to seek advice from local specialist services, which may provide details of alternatives to compulsory treatment and give advice about appropriate communication. However, any problem with availability of such services should not be allowed to delay action that is immediately necessary. It is desirable that, during examination or assessment, people with learning disabilities have someone with them whom they know well and with whom they have good communication (subject to the normal considerations of patient confidentiality).

18.15 The potential of co-morbidity with mental illness and personality disorder should also be kept in mind, in order that the skills of clinicians and others with appropriate expertise can be sourced and utilised at all points in the assessment, treatment and care pathway. The possibility of physical health problems underlying the presentation of abnormally aggressive or seriously irresponsible behaviour should always be kept in mind.



Chapter 19: People with personality disorders

Chapter 19

Personality disorders – general points.....	140
Personality disorders and mental health legislation.....	141
Assessment	141
Treatment	142
The development of assessment and treatment pathways.....	143

Chapter 19: People with personality disorders

19.1 This Chapter deals with issues of particular relevance to people with a personality disorder.

Personality disorders – general points

19.2 The Law applies equally to all people with mental disorders, including those with either a primary or secondary diagnoses of a personality disorder.

19.3 Some patients may have traits associated with a personality disorder but may not meet the criteria for the making of a formal diagnosis.

19.4 Generally, people who have personality disorders present with a complex range of mental health and other problems:

- many people may have traits or a diagnosis of more than one personality disorder and they may also have other mental health problems;
- self-harm, substance misuse problems and eating disorders are also common in people with personality disorders;
- some individuals experience very severe, periodic emotional distress in response to stressful circumstances and crises, particularly people with borderline personality disorder;
- some individuals can at times display a type of psychosis that is qualitatively different from that displayed by people with a diagnosis of mental illness;
- people with personality disorders usually have long-standing and recurrent relationship difficulties;
- people with personality disorders are more likely to experience housing problems and long-term unemployment;
- a small subgroup of people with personality disorders may exhibit anti-social behaviours and behaviours which pose risk to others; and
- antisocial personality disorder is strongly associated with offending. It is estimated that personality disorders have a high prevalence within offender populations.

Personality disorders and mental health legislation

19.5 People with personality disorders who are subject to compulsory measures under the Law may include individuals who:

- have a primary diagnosis of personality disorder and present a serious risk to themselves or others (or both);
- have complex mental disorders, including personality disorder, and present a serious risk to themselves or others (or both);
- have a primary diagnosis of personality disorder or complex disorders including personality disorder and are transferred from prison for treatment in secure psychiatric or personality disorder in-patient services; and
- are personality disordered offenders who have completed in-patient treatment in specialist units in other jurisdictions, or other secure settings, but who may need further treatment in the community.

Assessment

19.6 People with personality disorders may present and behave in very different ways from those with other mental disorders. It is important that such behaviours and presentations are properly understood if the Law is to be used appropriately.

19.7 Especially in times of crisis, decisions about the use of the Law for people with personality disorders will often have to be made by professionals who are not specialists in the field. It is therefore important that AOs and doctors carrying out assessments have a sufficient understanding of personality disorders.

19.8 The managers of community mental health teams and of inpatient units have a responsibility to ensure that all staff members who are likely to come into contact with patients with a diagnosis of (or traits of) a personality disorder, are adequately trained in understanding the nature and manifestation of personality disorder.

19.9 Individuals who have historically been labelled by various local agencies as having a personality disorder may never have had a thorough clinical assessment and formulation. A number of validated assessment tools enable a more precise identification to be made. Professionals will need to ensure that any treatment and after-care plans are shaped by appropriate clinical assessments conducted by suitably trained practitioners.

19.10 Detention of individuals with diagnoses of personality disorder should be avoided wherever possible. It is acknowledged that admission to enable the management of specific crises will sometimes be necessary. In emergency or very high-risk situations where an application for detention under the Law is being considered, responding to the immediate risk to the health or safety of the patient or to other people is the first priority. However, achieving an appropriate clinical assessment and formulation should be the immediate aim of detention.

Treatment

19.11 Patients who have been detained may often need to continue treatment in a community setting on discharge. Where there are continuing risks that cannot otherwise be managed safely, the use of extended or indefinite Article 24 Leave may provide a framework within which such patients can safely be treated in the community.

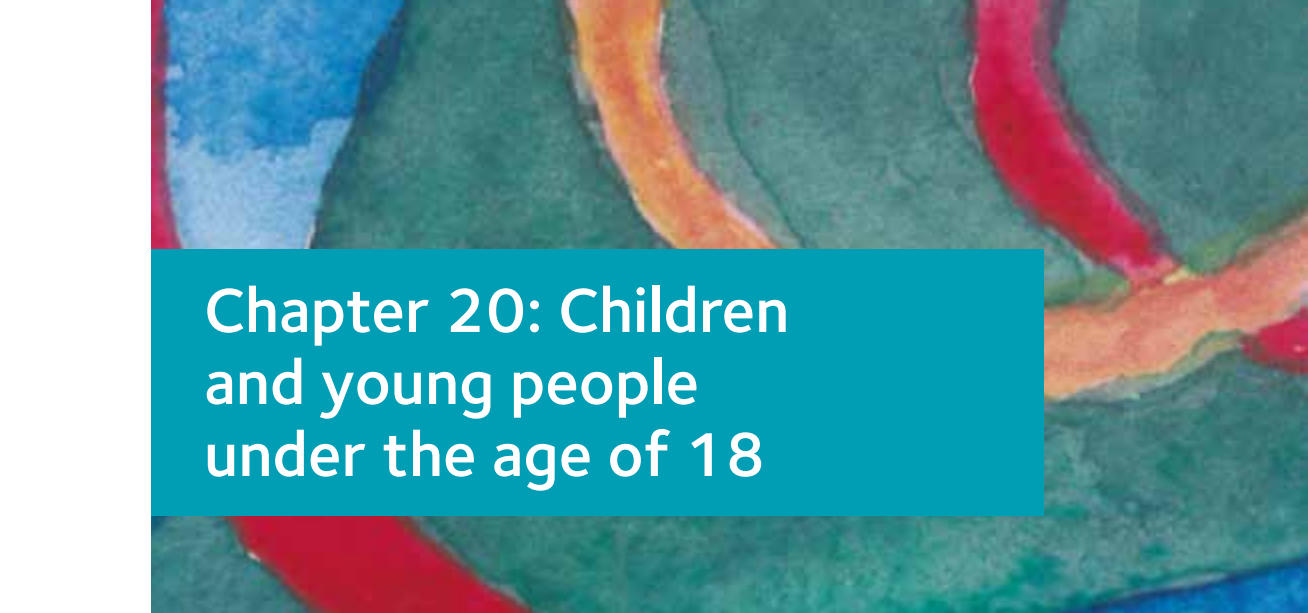
19.12 In deciding whether treatment under the Law can be delivered safely in the community, account should be taken of:

- where the specific model of treatment intervention can be delivered most effectively and safely;
- if management of personal and social relationships is a factor in the intervention, how the appropriate day-to-day support and monitoring of the patient's social as well as psychological needs can be provided;
- to what degree the psycho-social model of intervention requires the active participation of the patient for an effective and safe outcome;
- the degree to which the patient has the ability to take part in a psycho-social intervention that protects their own and others' safety;
- the degree to which 24-hour access to support will be required; and
- the need for the intervention and associated plan to be supervised by a professional who is appropriately qualified in the model of intervention and in risk assessment and management in the community.

19.13 In the case of personality disordered offenders who may already have received long-term treatment programmes within secure or prison settings, treatment in the community may well still be required while they resettle in the community.

The development of assessment and treatment pathways

- 19.14** Patients who meet the criteria for a diagnosis of personality disorder are as entitled to a service from mental health services as are other patients.
- 19.15** An agreed and appropriately validated assessment tool needs to be available to facilitate the diagnosing of personality disorders. This tool needs to be utilised consistently.
- 19.16** A range of therapies should be available. Possible therapies may include but are not limited to psychodynamic psychotherapy, cognitive behaviour therapy (CBT), dialectical behaviour therapy (DBT), scheme-focussed therapy and cognitive analytic therapy (CAT).
- 19.17** The emphasis of service delivery must be upon early intervention as opposed to crisis management.
- 19.18** Mental health teams are required to develop designated pathways to inform assessment and treatment of patients with the traits of or a diagnosis of a personality disorder. Such pathways must be based upon and informed by best practice, contemporary evidence and the experiences/feedback of patients and their carers.



Chapter 20: Children and young people under the age of 18

Chapter 20

General considerations	145
Parental responsibility.....	146
People with parental responsibility.....	146
Children looked after by the Department.....	148
Scope of parental control	148
Care for children whose liberty may need to be restricted: deciding between the Law or the Children Law	149
Decisions on admission and treatment of under 18s	150
Young people (16 and 17 year olds).....	150
Children under 16 years old and Gillick competence.....	152
Informal admission and treatment of children who are Gillick competent.....	153
Informal admission and treatment of under 16s who are not Gillick competent.....	153
Emergency treatment	154
Treatments for under 18s regulated by the Law	154
Treatment requiring the patient's consent	154
Other treatment under the Law – detained patients only	155
Applications to the court.....	155
Age-appropriate services	156
The approved practitioner and others caring for and treating under 18s.....	157
Rights to apply to the Tribunal	157
Education	157
Confidentiality	158
Duties of the Department in relation to patients in Approved Establishments or off-island hospitals	158

Chapter 20: Children and young people under the age of 18

20.1 This Chapter gives guidance on particular issues arising in relation to children (less than 16 years old) and young people (16 or 17 years old). This distinction is not made in the Law but is made in the Capacity Law. People aged 16 years and older are to be regarded as having the capacity to make their own decisions unless it is proven otherwise.

General considerations

20.2 The legal framework governing the admission to Approved Establishments and the treatment of children and young people is complex, and it is important to remember a number of factors. Those responsible for the care of children and young people in an Approved Establishment should be familiar with other relevant legislation, including the Children Law, the Human Rights (Jersey) Law, 2000, and the United Nations Convention on the Rights of the Child, as well as relevant case law and common law principles.

20.3 When making decisions under the Law about children and young people, the following should always be borne in mind:

- the welfare of the child or young person must always be the paramount consideration. Article 2(3) of the Children Law provides details of what areas should be considered in assessing a child's welfare;
- children and young people should always be kept as fully informed as possible, just as an adult would be. They should receive clear and detailed information concerning their care and treatment. This should be explained in a way they can understand and in a format that is appropriate to their age;
- the child or young person's views, wishes and feelings should always be considered;
- any intervention in the life of a child or young person that is considered necessary by reason of their mental disorder should be the option that is least restrictive to meet the required aims. This should be consistent with effective care and treatment. It should also result in the least possible separation from family, carers, friends and community or interruption of their education, as is consistent with their wellbeing;

- all children and young people should receive the same access to education provision as their peers;
- children and young people have as much right to expect their dignity to be respected as anyone else; and
- children and young people have as much right to privacy and confidentiality as anyone else.

Parental responsibility

20.4 Parental responsibility in Article 1 of the Children Law is defined as, *“all the rights, duties, powers, responsibilities and authority which the father of a legitimate child had in relation to the child and the child’s property prior to the commencement of Part 1, save that rights in respect of custody shall not be exclusive”*. Effectively therefore parental responsibility is bestowed upon the legitimate mother and father equally.

Parental responsibility is defined as encompassing a number of roles, the most important of which are to provide a home for the child and protect and maintain them financially. Parental responsibility also includes the roles of:

- disciplining the child
- choosing and providing for the child’s education
- ordinarily agreeing to the child’s medical treatment
- naming the child and agreeing to any change of name
- looking after the child’s property.

20.5 For the purposes of exercising parental responsibility, except where it is shown to the contrary, it would rarely be safe or appropriate for a child under 13 years of age to consent to treatment without parental participation in decision making.

People with parental responsibility

20.6 Those with parental responsibility will usually be the mother (unless the child is legally adopted by someone else) and father (in certain circumstances) of the child or young person. For example:

- The child’s father, if he was not married to the mother at the time of the birth but is named on the birth certificate (applies only to births registered after the 2nd December 2016).
- The child’s father, if he was married to the mother at the time of the birth, or if the child is jointly adopted.

- An unmarried father can acquire parental responsibility in several different ways; marry the mother of the child and re-register the birth; a formal parental responsibility agreement between himself and the child's mother; or apply for a parental responsibility agreement by application to the court.
- A person in whose favour the court has made a residence order concerning the child.

20.7 It is essential that those making decisions under the Law are clear about who has parental responsibility and that they always request copies of any court orders relating to this. These orders may include but are not limited to:

- residence orders
- contact orders
- interim and full care orders
- evidence of appointment of a tuteur or a guardian (under Article 7 of the Children Law).

If the parents of a child or young person are separated, and the child or young person is living with one parent, the person responsible for the care and treatment of the patient should try to establish whether there is a residence order and, if so, in whose favour.

20.8 Once it is established who has parental responsibility for the child or young person, the person responsible for the care and treatment of the child or young person must determine whether a person with parental responsibility has the right to make a decision about the child or young person's treatment and whether the decision is within the scope of parental control. It should also be noted that the exercise of parental responsibility should be consistent with the child's developing decision-making ability (which will be dependent upon a child's maturity and development).

20.9 Under the Children Law, consent to treat a child or young person is needed from only one person with parental responsibility. However it is good practice to involve all those with parental responsibility and any others with responsibilities in caring for the child in the decision making process and, where possible, to resolve matters by agreement. However, if one person with parental responsibility strongly disagreed with the decision to treat and was likely to challenge it in court, it might be appropriate to seek a declaration from the court that the treatment is in the child's best interests and can be given.

Children looked after by the Department

- 20.10** If a child or young person is voluntarily accommodated by the Department, parents or other people with parental responsibility have the same rights and responsibilities in relation to treatment as they would have if the child was not accommodated.
- 20.11** There are a number of orders within the Children Law which may involve sharing or restricting parental responsibility. If there is active Children's Service involvement it would be necessary to clarify the position of the Minister and other relevant parties in respect of parental responsibility.
- 20.12** In situations where a child is not in the family home as a result of the child being taken into formal accommodation on behalf of the Minister, it would be necessary to clarify the position of the Minister and other relevant parties in respect of parental responsibility. This is because those with day to day care responsibility for the child, such as foster carers, may not have any parental rights of responsibility for the child in their care.

Scope of parental control

20.13 People with parental responsibility may in certain circumstances consent on behalf of a child to them being given medical treatment or being admitted informally for such treatment. Even in these circumstances, mental health professionals can rely on such consent only where it is in the scope of parental control. This may also apply to young people who are given medical treatment and/or admitted for such treatment for a mental disorder and they lack the ability to consent for themselves. The concept of the scope derives largely from case law from the European Court of Human Rights. It is difficult to have clear rules about what may fall in the scope, when so much depends on the particular facts of each case. Certain guidelines are set out below, but where there is doubt professionals should take legal advice so that account may be taken of the most recent case law.

20.14 In assessing whether a particular decision falls within the parameters of the scope, two key areas must be considered:

- firstly, that the decision is one that a parent would be expected to make, having regard both to what is considered to be normative parenting in our society in respect of a child of that age and to any relevant human rights decisions made by the courts; and
- secondly, there are no indications that the parent might act against the best interests of the child or young person.

20.15 The less confident a professional is in relation to the two key areas, the more likely it will be that the decision in question falls outside the scope.

20.16 The scope cannot be clearly defined as it will vary from one case to the next. It is determined not only by social norms, the age of the child and stage of their development, but also by the circumstances and dynamics of the specific parent and child relationship. Mental health professionals might find it helpful to consider the following factors:

- the more the proposed treatment restricts the child's liberty, the more likely it will be that it falls outside the scope;
- whether the patient is resisting – treating a child or young person who is resisting requires more justification;
- the general social standards in force at the time concerning the sorts of decisions it is acceptable for parents to make – anything that goes beyond the kind of decision parents routinely make will require more scrutiny;
- the extent to which a parent's interests may conflict with those of the child or young person – this may suggest that the parent's ability to act in the child's best interests may be compromised.

20.17 For example, in a case where the parents had gone through an acrimonious divorce, it might not be possible to separate the decision about whether to admit the child to hospital from the parents' own relationship conflict, and it might not be possible to view the parents as able to make an impartial decision. In another case, there might be concerns about the capacity of the person with parental responsibility, and whether they have capacity to make a decision about the child's treatment.

20.18 It is also possible that a decision on treatment could be outside the scope simply because of the nature of the proposed treatment, for example in a situation where a type of treatment is considered to be particularly invasive.

20.19 In any case where reliance could not be placed on the consent of a person with parental responsibility, or on that of the child or young person, consideration should be given to alternative ways to treat them. One way would be to apply to have the child or young person detained under the Law, but this is available only where they meet all the criteria for such detention. In cases where they do not meet the criteria, it may be appropriate to seek a decision around treatment from the court under its inherent jurisdiction.

Care for children whose liberty may need to be restricted: deciding between the Law or the Children Law

20.20 There is no minimum age limit for detention in an Approved Establishment under the Law. It may be used to detain children or young people where it is justified by the risk posed by their mental disorder and all the relevant criteria are met.

- 20.21** In the event that a child or young person under the age of 18 is detained to an Approved Establishment, a strategy meeting must take place at the earliest available opportunity in order that the case be reviewed; that appropriate outcomes are agreed and with a view towards the period of detention being as short a period as possible.
- 20.22** There may be particular situations where a child or young person is at significant risk of being harmed or of harming others and where these risks cannot be safely managed in any type of environment other than secure accommodation. In the event that the Law does not apply, consideration could be given to Article 22 of the Children Law if there are specific concerns pertaining to the child's safety and welfare.
- 20.23** In respect of both laws, careful consideration needs to be made as to whether imposing such a significant restriction on a child or young person's liberty is the least restrictive and most appropriate outcome given the circumstances of the case. If less restrictive options are available and can safely be applied they must be implemented in the first instance.

Decisions on admission and treatment of under 18s

- 20.24** The decision to admit a child or young person to an Approved Establishment is inextricably linked to the decision to treat them once they have been admitted. However, they may need to be considered separately in light of the different provisions that are relevant to each decision.
- 20.25** At least one of the people involved in the assessment of a person who is under 18 years old should be a clinician specialising in treating children and young people. Where this is not possible, such a clinician should be consulted as soon as possible.

Young people (16 and 17 year olds)

Informal admission of young people with capacity to consent

- 20.26** A decision about admission for informal treatment of a person who has capacity must be made in accordance with Article 14 of the Law. This Article provides that where a patient is a young person who has capacity to consent to being admitted to an Approved Establishment for treatment of a mental disorder, they themselves may consent to being admitted, regardless of the views of a person with parental responsibility. This means that if a young person who has the capacity to make such a decision, consents to being admitted for treatment, they can be treated as an informal patient in accordance with Article 14, even if a person with parental responsibility is refusing consent.

- 20.27** Where a young person does not wish to be admitted informally, a person with parental responsibility does not have the power to insist that the young person is so admitted. Where a patient is a young person and has capacity but is unable to make a decision regarding informal admission for whatever reason, consideration should be given to whether the patient satisfies all the criteria for detention under the Law. If those criteria are not satisfied but treatment in an Approved Establishment is thought to be in the patient's best interests, it may be necessary to seek a declaration from the court under its inherent jurisdiction instead.
- 20.28** Young people aged 16 or over are assumed to have capacity unless there is evidence which indicates that they lack capacity. In which case, the processes as set out in the Capacity Law would apply.

Informal admission of young people who lack capacity to consent

- 20.29** Where a patient who is a young person but who does not have capacity to consent to informal admission, it should be considered whether the patient satisfies all the criteria for detention under the Law. If those criteria are not satisfied but admission to hospital is thought to be in the patient's best interests, a patient may be so admitted according to the Capacity Law. A parent or person with parental responsibility may not consent on the young person's behalf but should be consulted as part of the Best Interests process.

Informal treatment of young persons who are capable of consenting

- 20.30** Young people are assumed to be capable of consenting to their own medical treatment and to any ancillary procedures involved in that treatment, such as an anaesthetic. This applies equally to mental health as to physical health treatment.
- 20.31** A young person who has capacity to consent may nonetheless not be able to make a decision in a particular case, for example because they are overwhelmed by the implications of the relevant decision. In such instances, professionals should take the time to support the young person to think through the implications of the decision.
- 20.32** As would apply in the case of an adult, consent will be valid only if it is given voluntarily by an appropriately informed patient capable of consenting to the particular intervention.
- 20.33** The definition of treatment applies only to the young person's own treatment. It does not apply to an intervention that is not potentially of direct health benefit to the young person, such as non-therapeutic research into the causes of a disorder. However, a young person may be able to consent to such an intervention if they have the understanding and ability to do so.

- 20.34** When assessing whether a young person is capable of consent, the same criteria should be used as for adults.
- 20.35** If the young person is capable of giving valid consent and does so, then it is not legally necessary to consult with a person with parental responsibility as well. It is, however, good practice to involve the young person's family in the decision making process, if the young person consents to their information being shared.
- 20.36** When a young person refuses consent, it is beyond the scope of parental responsibility to authorise a significant restriction on liberty. This is defined in Article 39 of the Capacity Law.
- 20.37** In an emergency, where a young person who is capable of consenting refuses to have treatment, their decision can be overruled and the clinician can act without anyone's consent if the refusal would in all likelihood lead to their death or to severe permanent injury. It is always advisable in such circumstances that formal guidance and legal advice is sought promptly.

Children under 16 years old and Gillick¹ competence

- 20.38** In the case of Gillick, the court held that children who have sufficient understanding in respect of a proposed intervention will also have the competence to consent to that intervention. This is sometimes described as being "Gillick competent". A child may be Gillick competent to consent to admission to hospital, medical treatment, research or any other activity that requires their consent.
- 20.39** The standard of Gillick competence is used by professionals to measure a child's increasing development, understanding and maturity. The understanding required for different interventions will vary considerably. A child may have the competence to consent to some interventions but not others. The child's competence to consent should be assessed carefully in relation to each decision that needs to be made.
- 20.40** In some cases, for example because of a mental disorder, a child's mental state may fluctuate significantly, so that on some occasions the child appears to be Gillick competent in respect of a particular decision and on other occasions does not. In cases such as these, careful consideration should be given to whether the child is truly Gillick competent at the specific time when a decision needs to be made.
- 20.41** If the child is Gillick competent and is able to give consent to treatment after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. It is, however, good practice to involve the child's parents or other people with parental responsibility in the decision making process, if the child consents to their information being shared (or disclosure is permitted if there is reasonable cause to believe that the child is suffering or is likely to suffer significant harm).

Informal admission and treatment of children who are Gillick competent

- 20.42** Where a child who is Gillick competent to decide about their admission to hospital for assessment and/or treatment of their mental disorder consents to this, they may be admitted to hospital as an informal patient. A child who is Gillick competent and has consented to being admitted informally, may also be given treatment if they are competent to consent to the proposed treatment, and do consent. Consent will be required for each aspect of the child's care and treatment as it arises. This will involve an assessment of the child's competence to make the particular decision and, where the child is competent to do so, confirmation that they have given their consent.
- 20.43** Where a child who is Gillick competent refuses to be admitted for treatment it may be inadvisable to rely on the consent of a person with parental responsibility. In such cases, consideration should be given to whether admission under the Law is necessary, and if so, whether the criteria are met.
- If the Law is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Informal admission and treatment of under 16s who are not Gillick competent

- 20.44** Where a child is not Gillick competent then it may be possible for a person with parental responsibility to consent, on their behalf, to their informal admission to hospital for treatment for mental disorder. Before relying on parental consent an assessment should be made of whether the matter is within the scope of parental control.
- 20.45** If parental consent can be relied upon and consent is given by a person with parental responsibility, then the child may be admitted and treated as an informal patient.
- 20.46** Consent will be required for each aspect of the child's care and treatment as it arises. This will involve consideration as to whether the child is competent to make decisions about their treatment, and if not whether such treatment can be authorised by parental consent.
- 20.47** If it is not considered appropriate to rely on parental consent for the proposed admission and/or treatment, for example because the consent of a person with parental responsibility is not given or the matter is outside the scope of parental responsibility, the child cannot be admitted and treated informally. In such cases, consideration should be given to whether admission under the Law is necessary, and if so, whether the criteria are met.

- 20.48** In terms of treatment, where a child is Gillick competent, they may be given treatment if they are competent to consent to it and do consent.
- 20.49** A child's views should be taken into account, even if they are not Gillick competent, but the weight given to the child's views will depend on how emotionally mature the child is. Where a child has been Gillick competent to make a decision but then loses competence, any views they expressed before losing competence should be taken into account and may limit the scope of parental control in that circumstance.
- 20.50** If the decision is not within the scope of parental control, or the consent of a person with parental responsibility is not given, the child cannot be treated informally on the basis of the parent's consent. An application can be made under the Law if the child meets all the criteria for detention under the Law. If the criteria are not met, it may be necessary to seek authorisation from the court.

Emergency treatment

- 20.51** A life-threatening emergency may arise when a patient who is under 18 is capable of consenting to a treatment but refuses to do so, or where a person with parental responsibility could consent but it would be unreasonable to wait for their consent, or where they are refusing consent and there is no time to seek authorisation from the court. In such cases, it will be acceptable to undertake to preserve life or prevent irreversible serious deterioration of the patient's condition.

20

Treatments for under 18s regulated by the Law

- 20.52** Some specific treatments are regulated by the Law. The same restrictions apply for the treatment of mental disorder for patients under 18, as for other patients. The regulations have additional safeguards for children and young people.
- 20.53** Even where treatment under the Law does not require consent, consent should still be sought, wherever practicable. This may require an assessment of a child's competence using the Gillick standard about the proposed treatment.

Treatment requiring the patient's consent

- 20.54** Treatment covered by Part 6 of the Law would not ordinarily be given to a child or young person who does not consent, even if a person with parental responsibility consents, whether they are detained or not. However, it is in the power of the court to overrule a child or young person's refusal if they deem the treatment in the child's best interests.

Other treatment under the Law – detained patients only

20.55 The Law itself sets out when detained patients (of all ages) can be given other types of treatment for mental disorder, such as the requirement in Article 41 for consent or a second opinion before prescribed treatment or medication can be given to detained patients after the initial period of three months. People with parental responsibility are not required to consent to such treatment on behalf of children and young people in this position.

Applications to the court

20.56 In certain situations where decisions about admitting a child or young person informally or giving treatment need to be made and it is not appropriate to use the Law, the assistance of the court may be sought. Consideration will need to be given to whether an application should be made under the inherent jurisdiction or for a specific issue order under Article 10 of the Children Law. This will depend on the facts of each case. Where a child is under 16, an application should be considered, in particular where the child:

- is not Gillick competent and where the person with parental responsibility cannot be identified or is incapacitated;
- is not Gillick competent and where one person with parental responsibility consents but another strongly disagrees and is likely to take the matter to court themselves;
- is not Gillick competent and where there is concern that the person with parental responsibility may not be acting in the best interests of the child in making treatment decisions on behalf of the child, e.g. where relationship conflict between parents is a factor in any decision making or where there are concerns as to whether a person with parental responsibility is capable of making a decision in the best interests of the child;
- is not Gillick competent and where a person with parental responsibility consents but the decision is not within the scope of parental control e.g. where the treatment in question is ECT;
- is not Gillick competent and the Department holds parental responsibility for the child under a Care Order; or
- is Gillick competent or is a young person who is capable of making a decision on their treatment and is refusing treatment.

Age-appropriate services

20.57 Where possible, the Department should place children and young people who have been admitted to an Approved Establishment for the treatment of mental disorder in an environment that is suitable for their age (subject to their needs).

20.58 This means that where possible children and young people should:

- be provided with appropriate physical facilities;
- be treated and cared for by staff with the right training, skills and knowledge to understand their specific needs as children and young people;
- have an Approved Establishment routine that will allow their personal, social and educational development to continue as normally as possible; and
- have equal access to educational opportunities as their peers, in so far as that is consistent with their ability to make use of them, considering their mental state.

20.59 In the absence of a psychiatric ward specifically designated for children and young people, detention in a paediatric ward is preferable to detention in an adult ward. On the rare occasions where risk is such that detention in a paediatric ward is not practicable a child or young person detained in an adult ward must be accommodated in a discreet area which is separate from the adult areas. They should have facilities, security and staffing appropriate to the needs of the child or young person. They must be accommodated in single sex accommodation. A child or young person should not have contact with adults who are being accommodated or treated for psychiatric disorders. Where possible, all those involved in the care and treatment of children and young people should be child specialists. Any person who looks after them must always have enhanced disclosure clearance from the Disclosure and Barring Service and that clearance must be regularly updated.

20.60 In reaching a determination as to the suitability of an environment, the Department must consult a person whom it considers to be experienced in CAMHS cases.

- 20.61** It is important to recognise that there is a clear difference between a suitable environment for a child or young person in an emergency situation and a suitable environment for a child or young person on a longer term basis. In an emergency, such as when the patient is in crisis, the important thing is that the patient is in a safe environment. Once the initial emergency situation is over, the Department, in determining whether the environment continues to be suitable, would need to consider issues such as whether the patient can mix with individuals of their own age, can receive visitors of all ages and has access to education. The Department has a duty to consider whether a patient should be transferred to more appropriate accommodation and, if so, to arrange this as soon as possible.
- 20.62** There may be times when the assessment concludes that the best place for an under 18 year old is an adult ward. This may happen when the young person is very close to their 18th birthday, and placing the young person on a paediatric ward for a matter of weeks or days and then transferring them to an adult ward would be counter therapeutic. In such instances the rationale for such a decision must be clearly documented.
- 20.63** Children and young people aged under 18 should also have access to age-appropriate leisure activities and facilities for visits from parents, guardians, siblings or carers.

The approved practitioner and others caring for and treating under 18s

- 20.64** Where possible, those responsible for the care and treatment of children and young people should be child specialists. Where this is not possible, it is good practice for the clinical staff to have regular access to and make use of a CAMHS specialist for advice, consultation and supervision.

Rights to apply to the Tribunal

- 20.65** Children and young people who are detained under the Law have the same rights as other patients to apply to the Tribunal. It is important that children and young people are given assistance so that they can get access to legal representation at an early stage.

Education

- 20.66** No child or young person who would normally be in receipt of full-time compulsory education should be denied access to learning merely because they are receiving medical treatment for a mental disorder. Young people over school leaving age should be encouraged to continue learning.

Confidentiality

20.67 All children and young people have a right to confidentiality. Children under 16 years old who are Gillick competent and young people aged 16 and 17 years old are entitled to make decisions about the use and disclosure of information they have, providing confidence in the same way as adults. For example, they may be receiving treatment or counselling that they do not want their parents (or other people with parental responsibility) to know about. However, there are circumstances when the duty of care to the patient might require confidentiality to be breached to the extent of informing those with parental responsibility.

20.68 The decision to disclose information to parents and others with parental responsibility is complex for this age group and depends on a range of factors, including:

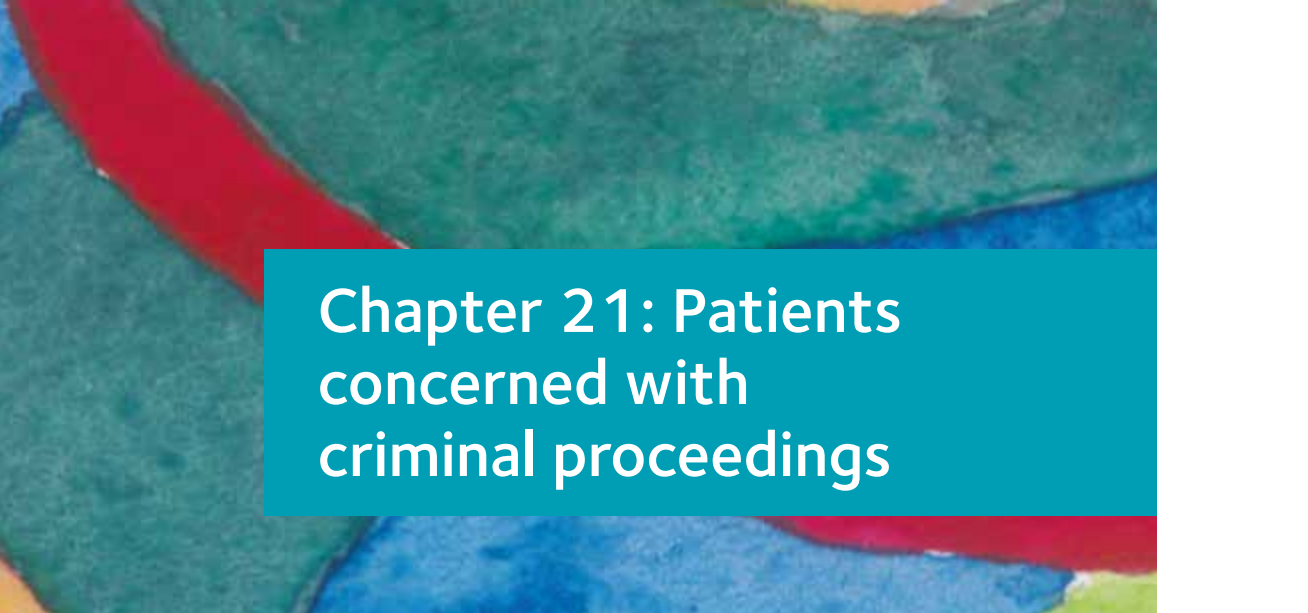
- the child or young person's age and developmental level
- their maturity
- their ability to take into account the future as well as the present
- the severity of the mental disorder and the risks posed to themselves and to others
- the degree of care and protection required
- the degree of the parent's involvement in the care of the child or young person
- the closeness of the relationship with the parents (or other people with parental responsibility), and
- the current competence of the child or young person to make a decision about confidentiality.

20.69 In addition, it should be noted that competence to make a decision about information sharing, as with treatment, may change over time.

Duties of the Department in relation to patients in Approved Establishments or off-island hospitals

20.70 There is a general duty on the Department, as a public authority, to promote contact under the Human Rights Law (Article 8 of the ECHR), on the basis that it is normally in the best interests of a child to have ongoing contact with both parents and it is the responsibility of a public authority to take reasonable steps to promote such contact.

1. Gillick v West Norfolk and Wisbech Area Health Authority (1986) A.C.112.



Chapter 21: Patients concerned with criminal proceedings

Chapter 21

Assessment for potential admission to an Approved Establishment.....	160
Diversion from criminal justice processes.....	160
The Department’s responsibilities.....	161
Assessment by an approved practitioner.....	161
Independent medical assessment.....	162
Reports to the court.....	162
Availability of appropriate Approved Establishment.....	164
Children and young people in custody.....	164
Medical assessment of children and young people.....	164
Transport to and from court.....	164
Treatment without consent – accused persons remanded for report.....	165
Transfer of prisoners to Approved Establishment.....	165
Hospital Treatment authorisations.....	166
Restriction Orders.....	166
Community leave.....	166
Jersey multi-agency public protection arrangements (JMAPP).....	167

Chapter 21: Patients concerned with criminal proceedings

21.1 This Chapter offers guidance on the use of the Law to arrange treatment for mentally disordered people who come into contact with the criminal justice system.

Assessment for potential admission to an Approved Establishment

21.2 People who are subject to criminal proceedings have the same rights to psychiatric assessment and treatment as anyone else. Any person who is in police or prison custody or before the courts charged with a criminal offence and who is in need of medical treatment for mental disorder should be considered for admission to an Approved Establishment.

21.3 Wherever possible, people who appear to the court to be mentally disordered should have their treatment needs considered at the earliest possible opportunity by alerting the relevant community mental health team. Such people may be at greatest risk of self-harm while in custody. Prompt access to specialist treatment may prevent significant deterioration in their condition and is likely to assist in a speedier trial process, helping to avoid longer-term harm or detention in an unsuitable environment.

21.4 If criminal proceedings are discontinued, it may be appropriate to arrange for an AO to consider making an application for admission under Part 3 of the Law.

Diversion from criminal justice processes

21.5 Joint protocols need to be operationalised in order that appropriate outcomes for individuals of all ages who have mental health problems, learning disabilities and other needs, such as autism spectrum disorder, who come into contact with the youth and adult justice systems are achieved. The department, the police, the probation service and the prison service are required to work together in order to identify need, undertake appropriate assessment and to refer to appropriate services. The purpose of such protocols is to ensure that youth and adult justice practitioners are notified of specific health requirements and vulnerabilities of an individual which can be taken into account when decisions about charging and sentencing are made.

21.6 It is to be acknowledged that an individual who has a diagnosis of or the symptoms of a mental health condition will not necessarily be mentally unwell at the time of an assessment. As such the processing of an individual within a criminal justice pathway will sometimes be the appropriate outcome despite a diagnosis of or the symptoms of a mental health condition.

The Department's responsibilities

21.7 The Department should, if requested, provide the courts with comprehensive information on the range of facilities available for the admission of patients subject to the criminal justice process. They should also provide comprehensive information regarding paediatric beds that are (or could be made), available for younger patients.

21.8 The Department should also appoint a named person to respond to requests for information and ensure that prompt medical assessment of defendants is provided to assist in the speedy completion of the trial process and the most suitable disposal of the offender.

Assessment by an approved practitioner

21.9 An AP should bear in mind that, when asked to provide evidence in relation to a possible admission under Part 9 of the Law, the request is not for a general report on the defendant's condition but for advice on whether or not the patient should be diverted from prison by way of a hospital treatment authorisation.

21.10 AP's should:

- identify themselves to the person being assessed, explain who has requested the report and make clear the limits of confidentiality in relation to the report. They should explain that any information disclosed, and the medical opinion, could be relevant not only to medical disposal by the court but also to the imposition of a punitive sentence, or to its length; and
- request relevant pre-sentence reports, the Inmate Medical Record (if there is one) and previous psychiatric reports, as well as relevant documentation regarding the alleged offence. If any of this information is not available, the AP's report should say so clearly.

21.11 The AP, or one of them if two AP's are preparing reports, should have access to a bed, or take responsibility for referring the case to another person who does, if they propose to recommend admission to an Approved Establishment. In the case of a defendant under the age of 18, the AP should ideally have specialist knowledge of assessment and treatment of children and young people.

- 21.12** The AP should, where possible, identify and access other independent sources of information about the person's previous history (including convictions). This should include information from GP records, previous psychiatric treatment and patterns of behaviour.
- 21.13** Assessment for the admission of the patient is the responsibility of the AP but other members of the clinical team who would be involved with the person's care and treatment should also be consulted. A multi-disciplinary assessment should usually be undertaken if admission to an Approved Establishment is likely to be recommended. The AP should also contact Probation Services.
- 21.14** In cases where the AP cannot state with confidence at the time of sentencing whether a hospital treatment order will be appropriate, the AP should consider recommending an interim hospital treatment order under Article 64 of the Law. This order provides for the person to be admitted to an Approved Establishment for up to 12 weeks (which may be extended for further periods of up to 28 days to a maximum total period of 26 weeks) so that the court can reach a conclusion on the most appropriate and effective disposal.

Independent medical assessment

- 21.15** A patient who is remanded to an Approved Establishment for a report (Article 64) or for treatment (Article 65) is entitled to obtain, at their own expense, an independent report on their mental condition from a medical practitioner of their choosing, for the purpose of applying to court for the termination of the remand. The Approved Establishment managers should help in the exercise of this right by enabling the patient to contact a suitably qualified and experienced legal advocate or other advisor.

Reports to the court

- 21.16** Clinical opinion is particularly important in helping courts to determine the sentence to be passed. In particular, it will help to inform the decision whether to divert the offender from punishment by way of a hospital treatment order, or whether a prison sentence is the most suitable disposal.
- 21.17** A medical report for the court should set out:

- the material on which the report is based;
- how that material relates to the opinion given;
- where relevant, how the opinion may relate to any other trial issue;
- factors relating to the presence of mental disorder that may affect the risk that the patient poses to themselves or others, including the risk of re-offending; and

- if admission to an Approved Establishment is recommended, what, if any, special treatment or security is recommended and whether the AP represents an organisation that is able to provide what is required

21.18 The report should not speculate about guilt or innocence.

21.19 Where an offender is or appears to be mentally disordered, a court may request a medical report before passing sentence in order to consider any information which relates to the offender's mental condition and the likely effect of such a sentence on that condition and on any treatment that may be available for it.

21.20 It may, therefore, be appropriate to include recommendations on the disposal of the case. In making recommendations for disposal, the AP should consider the longer-term, as well as immediate, consequences. Factors to be taken into account include:

- whether the court may wish to make a hospital treatment order subject to special restrictions; and
- whether, for restricted patients, the order should designate admission to a named unit.

21.21 Where an offender is made subject to a hospital treatment order with special restrictions (restricted patients), the court may specify that the person be detained in a named unit within a hospital or an Approved Establishment. This is to ensure an appropriate level of security.

21.22 A named Approved Establishment unit can be any part of an Approved Establishment which is treated as a separate unit. It will be for the court to define what is meant in each case where it makes use of the power. The consent of the court will be required for any leave of absence or transfer from the named unit, whether the transfer is to another part of the Approved Establishment or to another Approved Establishment.

21.23 A hospital treatment order, with or without restrictions, diverts the offender from punishment to treatment. There is no tariff to serve, and the period of detention will be determined by the disorder and the risk of harm which attaches to it.

21.24 A hospital direction, under Article 67, by contrast, accompanies a prison sentence and means that from the start of the sentence the offender will be managed in hospital in the same way as a prisoner who has been transferred to hospital. The RMO can propose to the Minister that the prisoner be transferred to prison at any time before the prisoner's release date if in their opinion, treatment in hospital is no longer required and/or no effective treatment can be given.

Availability of appropriate Approved Establishment

21.25 If the medical evidence is that the person needs treatment in hospital, but the doctor cannot identify a suitable facility where the person could be admitted immediately, a plan needs to be formulated in order that a suitable facility might be sourced. Prison should not be regarded as the default option.

Children and young people in custody

21.26 It is recognised that the treatment of children and young people under the Law should be provided by specialist professionals; be appropriate for their age and clinical need and be planned and implemented effectively with minimum delay and disruption.

Medical assessment of children and young people

21.27 Medical assessments in the case of a defendant under the age of 18, should be undertaken by a professional with current clinical expertise, including specialist knowledge of child and adolescent mental health services (CAMHS). If this is not possible, professionals with the appropriate expertise and experience should be consulted.

Transport to and from court

21.28 For accused persons remanded to an Approved Establishment under Articles 62 or 63 of the Law, or persons subject to an Article 64 interim hospital treatment order or an Article 65 hospital treatment order, the court has the power to direct who is to be responsible for conveying the defendant from the court to the receiving Approved Establishment. In practice, when remand orders are first made, patients are usually returned to the holding prison and arrangements are then made to admit them to an Approved Establishment within the statutory period.

21.29 When a person has been admitted on remand or is subject to an interim hospital treatment order, it is the responsibility of the Approved Establishment to return the person to court as required. The court should give adequate notice of hearings. The Approved Establishment should liaise with the court in plenty of time to confirm the arrangements for escorting the person to and from court. The Approved Establishment will be responsible for providing a suitable escort for the person when travelling from the Approved Establishment to the court and should plan for the provision of necessary staff to do this. If possible, and having regard to the needs of the person, medical or nursing staff should remain with the patient on court premises, even though legal accountability while the person is detained for hearings remains with the court.

Treatment without consent – accused persons remanded for report

- 21.30** The rules in Article 63 and 65 of the Law about medical treatment of detained patients do not apply to accused persons remanded on bail under Article 61 for a report on their mental condition or remanded to an Approved Establishment under Article 62 for a report on their mental condition. As a result, treatment can be administered only with their consent.
- 21.31** Where an accused person remanded under Article 61 or 62 is thought to be in need of medical treatment for mental disorder which cannot otherwise be given, the person should be referred back to court by their AP as soon as possible with an appropriate recommendation and with an assessment of whether they are in a fit state to attend court.
- 21.32** If there is a delay in securing a court date, consideration should be given to whether the patient meets the criteria for detention under Part 3 of the Law to enable compulsory treatment to be given. This will be concurrent with, and not a replacement for, the remand made by the court.

Transfer of prisoners to Approved Establishment

- 21.33** The need for in-patient treatment for a prisoner should be identified and acted upon quickly, and prison healthcare staff should make contact immediately with the Department. The Department should aim to ensure that transfers of prisoners with mental disorders are carried out within a timeframe equivalent to levels of care experienced by patients who are admitted to mental healthcare services from the community. Any unacceptable delays in transfer after identification of need should be actively monitored and investigated.
- 21.34** Prisoners with a diagnosis of severe and enduring mental disorder who have given informed consent to treatment should also be considered for transfer to an Approved Establishment for treatment if the prison environment is considered to be contributing to their disorder. An assessment of need and regular review should consider whether the prison healthcare centre is capable of providing for the prisoner's care if they are considered to be too unwell or vulnerable to return to residential wings.
- 21.35** Prisoners transferred to an Approved Establishment by virtue of a hospital treatment authorisation under Article 65 should not be returned to prison unless clinical staff from the Approved Establishment and prison have met to plan the prisoner's future care.

Hospital Treatment authorisations

- 21.36** A patient subject to a hospital treatment authorisation can be detained in an Approved Establishment for up to 6 months from the date of the order. It can be renewed for up to 6 months, or successive periods of 12 months, by presenting to the Attorney General an application and any other documentation required by rules of court.
- 21.37** The hospital treatment authorisation can be discharged by the patient's RMO or by the Tribunal. There is no power for the patient's Nearest Person to give written notice to the RMO requesting that the RMO uses the power to discharge the patient.

Restriction Orders

- 21.38** The court may order that a hospital treatment authorisation shall take effect as a hospital treatment authorisation with special restrictions, and this order will be known as a restriction order. The court may or may not specify a time limit for this order.
- 21.39** The restriction order can be discharged by the court at any time if the court is satisfied, following an application made by either the defendant, the defendant's Nearest Person or the Attorney General (which will be founded upon the opinion of the RMO in the form of a report), that the restrictions are no longer required to protect the public from serious harm.
- 21.40** A person charged with an offence before the court but found not guilty by reason of insanity, or found unfit to plead, may also receive a hospital and restriction order under Articles 65 and 68.
- 21.41** A restriction order carries no time limit so the patient will remain detained in hospital for as long as they require treatment. Where the patient is also subject to a prison sentence and the patient is a restricted patient by virtue of Article 67, the restriction will fall away on the date that the patient would be released from prison.
- 21.42** All decisions about restricted patients, including about community leave, transfer, readmission or discharge are taken by the court.

Community leave

- 21.43** An RMO is required to obtain consent from the court before granting Article 24 leave to a restricted patient.
- 21.44** The court may consent to programmes of leave which give RMO's discretion as to leave arrangements. The expectation however is that the leave will be designed and conducted in such a way as to preserve public safety and, where appropriate, respect the feelings and fears of victims and others who may have been affected by the offences.

- 21.45** Requests to the court for leave must be made on the designated form. The attachment of leave plans may be useful. In the event that consent for leave is given, RMO's should be aware that the Court may request additional reports on the restricted patient as considered necessary.
- 21.46** Should there be any concerns or doubts about the leave being taken, it should be suspended and the court should be informed.

Jersey multi-agency public protection arrangements (JMAPP)

- 21.47** Health and Community services have a duty to co-operate with the JMAPP responsible authorities in assessing and managing the risk of JMAPP eligible mentally disordered offenders.
- 21.48** JMAPP is the framework of statutory arrangements operated by criminal justice and other agencies that seek to manage and reduce the risk presented by sexual and violent offenders in order that re-offending is reduced and the public is protected. This is done by the sharing of information and the establishment of a coordinated risk management plan that will allow offenders, including Part 3 patients, to be effectively managed.
- 21.49** There are four categories of offender eligible for JMAPP, all of which may come to the attention of health services as Part 3 patients:

- **Category 1 Offenders:** Registered Sex Offenders

This Category includes offenders convicted of a relevant offence as defined in Article 2 of the Sex Offenders (Jersey) Law 2010 and those required to comply with the notification requirements under Articles 13 and 14 of this Law.

- **Category 2 Offenders:** Violent Offenders

This Category includes:

Offenders sentenced to 12 months in custody or longer for their most recent violent offence.

- **Category 3 Offenders:**

This category is comprised of offenders, not in either Category 1 or 2, but who are considered by the referring agency to pose a risk of serious harm to the public which requires active inter-agency management.

To register a Category 3 offender, the referring agency must satisfy the JMAPP Co-ordinator that:

- the person has committed an offence which indicates that they are capable of causing serious harm to the public; and
- reasonable consideration has indicated that the offender may cause serious harm to the public, which requires a multi-agency approach at Level 2 or 3 to manage the risks

The offence may have been committed in any geographical location, which means that offenders convicted abroad could qualify.

Any agency can identify an offender who may qualify for Category 3.

- **Category - Potentially Dangerous Persons (PDPs):**

Association of Chief Police Officers (2007) - *Guidance on Protecting the Public: Managing Sexual and Violent Offenders* defines a PDP as:

“a person who has not been convicted of, or cautioned for, any offence placing them in one of the three JMAPP categories (see above), but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm”

Serious harm can be defined as an event, which is life threatening and/or traumatic, from which recovery, whether physical or psychological, can be expected to be difficult or impossible. Risk of serious harm is the likelihood of this event happening. It should be recognised that the risk of serious harm is a dynamic concept and should be kept under regular review.

21

21.50 JMAPP offenders can be managed at one of three levels based upon the level of multi-agency co-operation that is required to implement the offender's risk management plan effectively. Offenders move up and down levels as appropriate.

The levels are:

- **Level 1** – ordinary management: These offenders are subject to the usual management arrangements applied by whichever agency is responsible for their supervision. This does not rule out information sharing between agencies; the JMAPP framework provides for important information to be shared by and between agencies. Risk of harm presented by Level 1 offenders, even where assessed as high, can be managed effectively without a multi-agency meeting
- **Level 2** – active multi-agency management: The risk management plans for these offenders require the active involvement of several agencies via regular multi-agency public protection (MAPP) meetings

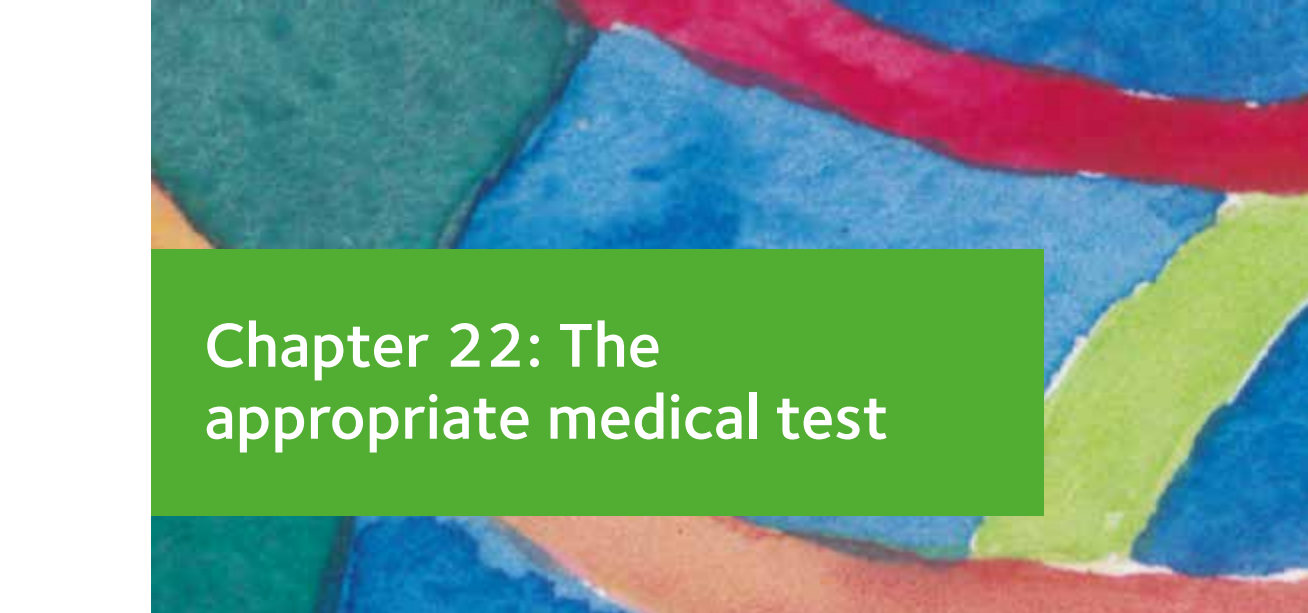
- **Level 3** – active multi-agency management: As with Level 2 offenders the risk management plans for these offenders require the active involvement of several agencies via regular MAPP meetings. In addition, these cases require the involvement of senior officers from the relevant agencies to authorise the use of special resources, such as police surveillance or specialised accommodation, or to provide ongoing senior management oversight of the case.

21.51 Providers should ensure that all RMOs receive regular refresher professional development on the requirements in the JMAPP framework and are satisfied that staff are adhering to the requirements set out in it. Professional development should particularly include the need to adopt a thoroughly investigative approach to any concerns that arise during supervision for restricted Part 3 patients within the JMAPP framework where they have been convicted of serious offences.

Section 5: Care, support and treatment in hospital

Why read this section?

These chapters address issues relating to the care and treatment of patients. Guidance is provided in respect of the appropriate medical test, medical treatment and medical treatment under the Law and on treatments which are subject to special rules and procedures under the Law. Specific guidance is provided in respect of safe and therapeutic responses to disturbed behaviour and in respect of the use of restrictive interventions.



Chapter 22: The appropriate medical test

Chapter 22

Purpose of medical treatment for mental disorder.....	173
Applying the appropriate medical treatment test	174
Patients with dementia.....	176

Chapter 22: The Appropriate Medical Test

22.1 This Chapter provides guidance on the application of the appropriate medical treatment test and the criteria for detention under the Law. It includes guidance on appropriate treatment for people with dementia.

Purpose of medical treatment for mental disorder

22.2 For the purposes of the Law, medical treatment includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care. Habilitation means equipping someone with skills and abilities they have never had, whereas rehabilitation means supporting them recover skills and abilities they have lost.

22.3 In the Law, medical treatment for mental disorder means medical treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations.

22.4 Purpose is not the same as likelihood. Medical treatment must be for the purpose of alleviating or preventing a worsening of mental disorder even if it cannot be shown, in advance, that a particular effect is likely to be achieved.

22.5 Symptoms and manifestations include the way a disorder is experienced by the individual concerned and the way in which the disorder manifests itself in the person's thoughts, emotions, communication, behaviour and actions. It should be remembered that not every thought or emotion or every aspect of the behaviour, of a patient suffering from mental disorder will be a manifestation of that disorder.

22.6 Even if particular mental disorders are likely to persist or get worse despite treatment, there may well be a range of interventions which would represent appropriate medical treatment. It should never be assumed that any disorders, or any patients, are inherently or inevitably untreatable. Nor should it be assumed that likely difficulties in achieving long-term and sustainable change in a person's underlying disorder make medical treatment to help manage their condition and the behaviours arising from it either inappropriate or unnecessary.

- 22.7** The Law requires appropriate and lawful medical treatment to be available to a patient in order to meet the criteria for both Article 21 and 22 detention. Where the appropriate medical treatment test forms part of the criteria for detention, the medical treatment in question is treatment for mental disorder in the Approved Establishment in which the patient is to be detained.
- 22.8** The appropriate medical treatment test must be applied to ensure that no one is detained (or remains detained) for treatment, or is provided with leave of absence, unless medical treatment for their mental disorder is both appropriate and available.
- 22.9** In order to be deemed appropriate, medical treatment must be for the purpose of alleviating or preventing a worsening of the patient's mental disorder or its symptoms or manifestations. It must also be appropriate, having taken account of the nature and degree of the patient's mental disorder and all their particular circumstances, including cultural, ethnic and religious or belief considerations.
- 22.10** The appropriate medical treatment test requires a judgement about whether an appropriate treatment or package of treatment for mental disorder is available for the individual in question. It is not consistent with the least 'restrictive option and maximising independence' and 'purpose and effectiveness' guiding principles' to detain someone for treatment that is not actually available or may not become available until some future point in time.

Applying the appropriate medical treatment test

22.11 The test requires a balanced and holistic judgement as to whether the medical treatment available to the patient is appropriate, given:

- the nature and degree of the patient's mental disorder, and
- all the other circumstances of the patient's case. In other words, both the clinical appropriateness of the treatment and its appropriateness more generally must be considered.

22.12 The other circumstances of a patient's case might, for example, include factors such as:

- the patient's physical health – how this might impact on the effectiveness of the available medical treatment for the patient's mental disorder and the impact that the treatment might have in return
- the patient's age
- any physical disabilities or sensory impairments the patient has
- the patient's culture and ethnicity

- the patient's gender, gender identity, sexual identity and sexual orientation
- the patient's religion or beliefs
- the location of the available treatment
- the implications of the treatment for the patient's family and social relationships, including their role as a parent (where applicable)
- its implications for the patient's education or work
- the consequences for the patient, and other people, if the patient does not receive the treatment available, and
- the patient's views and wishes about what treatment works for them and what does not.

22.13 Medical treatment must always be an appropriate response to the patient's condition and situation and indeed wherever possible should be the most appropriate treatment available. It may be that a single medical treatment does not address every aspect of a patient's mental disorder.

22.14 Medical treatment must actually be available to the patient. It is not sufficient that appropriate treatment could theoretically be provided.

22.15 What is appropriate will vary greatly between patients. It will depend, in part, on what might reasonably be expected to be achieved given the nature and degree of the patient's disorder.

22.16 Medical treatment which aims merely to prevent a disorder worsening is unlikely, in general, to be appropriate in cases where normal treatment approaches would aim (and be expected) to alleviate the patient's condition significantly. However, for some patients with persistent and severe mental disorders, management of the undesirable effects of their disorder may be the most that can realistically be hoped for.

22.17 Appropriate medical treatment does not have to involve medication or psychological therapy – although it very often will. There may be patients whose particular circumstances mean that treatment may be appropriate even though it consists only of nursing and specialist day-to-day care under the supervision of a clinician in a safe and secure therapeutic environment with a structured regime.

22.18 Simply detaining someone, even in a hospital, does not constitute medical treatment.

22.19 A patient's attitude towards the proposed treatment may be relevant in determining whether the appropriate medical treatment test is met. An indication of unwillingness to co-operate with treatment generally, or with a specific aspect of treatment, does not make such treatment inappropriate.

- 22.20** In particular, psychological therapies and other forms of medical treatments which, to be effective, require the patient's co-operation are not automatically inappropriate simply because a patient does not currently wish to engage with them. Such treatments can potentially remain appropriate and available as long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to engage.
- 22.21** In determining whether the appropriate medical treatment test is met, those making the judgement must satisfy themselves that appropriate medical treatment is available for the time being, given the patient's condition and circumstances as they are currently understood. Determinations are time specific and may need to be reconsidered as the patient's condition changes or clinicians obtain a greater understanding of the patient's case.

Patients with dementia

- 22.22** Generally, treatment approaches for dementia differ according to the type of dementia the person has. People with dementia can benefit from approaches that do not involve drugs, e.g. reminiscence therapy or cognitive stimulation therapy. People with dementia may experience depression or anxiety and it may be appropriate to offer them antidepressant drugs and/or offered talking therapies.
- 22.23** Some people with dementia may exhibit particular behaviours because they are distressed, confused or in pain. The use of sedation or antipsychotic medication may not be appropriate in these circumstances and alternative intervention or treatment could be deemed more appropriate.



Chapter 23: Medical treatment

Chapter 23

Definitions.....	178
Appropriate treatment	179
Treatments to which special rules and procedures apply.....	179
Treatment of detained patients and patients on leave but recalled to hospital (Part 3 of the Law).....	179
Treatment of detained patients	180
Treatment of patients on leave	181
Treatment of other patients.....	181
Capacity and consent.....	181
Capacity – the basic principles.....	182
Consent.....	183
Capacity to consent: people aged 16 or over.....	183
Competence to consent to treatment – children under 16.....	184
Treatment without consent – general points	185
Treatment plans.....	185
Emergency treatment.....	187
Decisions of courts not to give treatment	187

Chapter 23: Medical treatment

- 23.1** This Chapter gives guidance on medical treatment for mental disorder under the Law, especially treatment given without patients' consent. It also gives guidance on promoting good physical healthcare for patients subject to the Law.
- 23.2** Treatment under the Law must be appropriate to the patient's mental health condition and take account of the person's wishes or feelings and any ADRT's or Advance Statements. The Chapter provides guidance about appropriate treatment; treatments to which special rules and procedures apply; the treatment of detained patients and patients on leave and on issues of capacity and consent. It gives guidance on treatment plans, explaining their importance, and provides a summary of the treatment of incapacitated patients and the interface between the Law and the Capacity Law.

Definitions

- 23.3** The Law defines *treatment* as treatment for mental disorder. This can include psychiatric or physical treatment or nursing, medication, cognitive, behavioural or other therapy, counselling or other psychological intervention and training or other rehabilitation. Such treatment may or may not be provided on a regular basis, and may or may not be provided in an Approved Establishment.
- 23.4** For the purposes of the Law, treatment should be understood as being for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations.
- 23.5** This includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder (e.g. treating wounds self-inflicted as a result of mental disorder). Equally, treatment for an eating disorder may take the form of physical intervention such as re-feeding. Otherwise, the Law does not regulate medical treatment for physical health problems.

Appropriate treatment

- 23.6** All treatment provided should be appropriate to the patient's mental health condition and take account of any ADRT's or Advance Statements made by the person and any wishes or feelings they have expressed in advance of treatment. The practicalities of how the treatment is to be delivered, and how outcomes will be monitored should be considered.
- 23.7** Where reasonably practicable, treatment should be based on a strong evidence- base. Professionals should ensure that any treatment is compliant with current guidelines and standards about what is appropriate treatment.

Treatments to which special rules and procedures apply

- 23.8** Article 40 and Article 41 set out types of medical treatment for mental disorder to which special rules and procedures apply, including, in many cases, the need for a certificate from SOAD approving the treatment.
- 23.9** Guidance on Articles 40 and 41 is provided in Chapter 25, but in summary the treatments involved are detailed below:

- Neurosurgery for mental disorder
- Surgical implantation of hormones to reduce male sex drive
- ECT

It is possible that other forms of treatment may be added to any of these Articles by regulations made by the Department.

Treatment of detained patients and patients on leave but recalled to hospital (Part 3 of the Law)

- 23.10** Part 3 of the Law deals mainly with the treatment of people who are liable to be detained in hospital, including patients who have been recalled to hospital from leave. They are referred to in this Chapter as 'detained patients'.
- 23.11** Unless Articles 40 or 41 apply, Article 39 of the Law means that detained patients may be given medical treatment for any kind for mental disorder, whether they:

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

However the treatment must be given by or under the direction of the RMO in charge of the treatment in question.

- 23.12** If Articles 40 or 41 apply, detained patients may be given the treatment only if the rules in those Articles are followed.

Treatment of detained patients

23.13 Part 6 of the Law deals mainly with the treatment of people who have been detained in an Approved Establishment.

23.14 In the Law “detained patients” means:

- Patients who are liable to be detained in an Approved Establishment under any Article of the Law (including those on leave of absence or absent without leave).
- Patients recalled from leave of absence.

Some patients detained in an Approved Establishment are not covered by these rules, as detailed below. When referring to detained patients, these patients are not included. There are no special rules about treatment for these patients – they are in the same position as patients who are not subject to the Law at all, and they have exactly the same rights to consent and to refuse treatment:

- Patients held in an Approved Establishment under the holding powers in Article 15 or 29
- Patients remanded on bail for a report on their mental condition under Article 61
- Patients remanded in hospital for a report of their medical condition under Article 62
- Patients detained in a place of safety under Article 35 or 36
- Restricted patients who have been conditionally discharged (unless or until they are recalled to hospital).

The Law cannot be used to treat these patients without their consent.

23.15 For the purposes of this Law, a patient is “liable to be detained” where that patient has, in most circumstances, been made subject to an order made under Part 4 or 5.

23.16 Unless Article 40 or 41, or any legislation in relation to ECT, applies, Article 39 of the Law means that detained patients may be given medical treatment for any kind of mental disorder, if they:

- consent to it, or
- have not consented to it, but the treatment is given by or under the direction of the responsible medical officer in charge of the treatment in question.

- 23.17** If Article 40 or 41, or any legislation in relation to ECT, applies, detained patients may be given the treatment only if the procedures in that legislation are followed (see Chapter 24).
- 23.18** In deciding whether patients object to treatment, all the relevant evidence should be taken into account, so far as it reasonably can be. In many cases, patients will be able to state their objection, either verbally or by their dissenting behaviour. However, in other cases, especially where patients are unable to communicate (or only able to communicate to a limited extent), RMOs will need to consider the patient's behaviour, wishes, views, beliefs and values, both present and past, so far as they can be ascertained.
- 23.19** If there is reason to think that a patient would object, if able to do so, then the patient should be taken to be objecting. Occasionally, it might be that the patient's behaviour initially suggests an objection to being treated, but is in fact not directed at the treatment at all. In that case the patient would not be taken to be objecting.

Treatment of patients on leave

- 23.20** A patient may be granted leave of absence from hospital by their RMO. Such leave may be for a short duration, a long duration or may be indefinite. However, in each case the patient will remain liable to be detained according to either Article 21 or 22. As a consequence such patients must adhere to treatment as prescribed or otherwise directed by their RMO. A failure to adhere to such a condition may mean that the patient is recalled to hospital.

Treatment of other patients

- 23.21** The Law does not regulate treatment of any other patients, except that:

- the special rules and procedures in Article 40 and 41 apply to all patients; and
- special rules and procedures apply to patients under the age of 18.

23

Capacity and consent

- 23.22** The Law frequently requires healthcare professionals to determine:

- whether a patient has the capacity to consent to or refuse a particular form of medical treatment, and
- if so, whether the patient does in fact consent.

The rules for answering these questions are the same as for any other patients.

23.23 In order for consent to be valid, the patient must have the capacity to consent. The patient must be provided with and be able to understand all of the salient information relevant to the decision for which consent is required. The patient must freely provide the consent without undue duress from a third party. The Department's Capacity Policy should be consulted in respect of the provision of valid consent.

Capacity – the basic principles

23.24 An individual is presumed to have the capacity to make a treatment decision unless the individual:

- is unable to take in and retain the information material to the decision especially as to the likely consequences of having or not having the treatment; or
- is unable to believe the information; or
- is unable to weigh the information in the balance as part of a process of arriving at the decision

23.25 When making decisions about patients under the Law, it should be remembered that:

- mental disorder does not necessarily mean that a patient lacks capacity to give or refuse consent, or to take any other decision;
- any assessment of an individual's capacity has to be made in relation to the particular decision being made – a person may, for example, have the capacity to consent to one form of treatment but not to another;
- capacity in an individual with a mental disorder can vary over time and should be assessed at the time the decision in question needs to be taken;
- where a person's capacity fluctuates, consideration should be given, if a decision is not urgently required, to delaying the decision until the person has capacity again to make it for themselves;
- not everyone is equally capable of understanding information in the same way – explanations should be appropriate to the level of the patient's assessed ability; and
- all assessments of a patient's capacity should be fully recorded in their notes

Consent

- 23.26** Valid consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not valid consent.
- 23.27** By definition, a person who lacks capacity to consent does not consent to treatment, even if they co-operate with the treatment or actively seek it.
- 23.28** It is the duty of everyone seeking consent to use reasonable care and skill, not only in giving information prior to seeking consent, but also in meeting the continuing obligation to provide the patient with sufficient information about the proposed treatment and alternatives to it.
- 23.29** The information which must be given must be related to the particular patient, the particular treatment and relevant clinical knowledge and practice. In every case, sufficient information must be given to the patient to ensure that they understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it. A record should be kept of information provided to patients.
- 23.30** Patients should be invited to ask questions and professionals should answer fully, frankly and truthfully. There may sometimes be a compelling reason, in the patient's interests, for not disclosing certain information. A professional who chooses not to disclose information must be prepared to justify the decision and must document his reason for withholding it. A professional who chooses not to answer a patient's question should make this clear to the patient and provide his rationale for this decision.
- 23.31** Patients should be told that their consent to treatment can be withdrawn at any time. Where patients withdraw their consent (or are considering withdrawing it), they should be given a clear explanation of the likely consequences of not receiving the treatment and (where relevant) the circumstances in which the treatment may be given without their consent under the Law. A record should be kept of the information provided to patients.

23

Capacity to consent: people aged 16 or over

- 23.32** Under the Consent to Medical Treatment (Jersey) Law 1973 those who have attained the age of 16 years can consent to medical treatment in their own right even though they are still minors (under 18). For people aged 16 or over, capacity to consent is defined by the Capacity Law. The principles of the Capacity Law state (among other things) that:

- people must be assumed to have capacity unless it is established that they lack capacity
- people are not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success
- people are not to be treated as unable to make a decision merely because they make an unwise decision.

23.33 When taking decisions about patients under the Law, it should be remembered that:

- mental disorder does not necessarily mean that a patient lacks capacity to give or refuse consent, or to take any other decision
- any assessment of an individual's capacity has to be made in relation to the particular decision being made – a person may, for example, have the capacity to consent to or refuse one form of treatment but not to another
- capacity in an individual with a mental disorder can vary over time and should be assessed at the time the decision in question needs to be taken
- where a patient's capacity fluctuates in this way, consideration should be given, if a decision is not urgently required, to delaying the decision until the patient has capacity again to make it for themselves
- not everyone is equally capable of understanding the same explanation – explanations should be appropriate to the level of the patient's assessed ability, and
- all assessments of an individual's capacity should be fully recorded in the patient's notes.

23

Competence to consent to treatment – children under 16

23.34 The Capacity Law does not apply to medical treatment for children under 16. In the case of Gillick, the court held that children who have sufficient understanding in respect of a proposed intervention will also have the competence to consent to that intervention. This is sometimes described as being "Gillick competent". A child may be Gillick competent to consent to admission to hospital, medical treatment, research or any other activity that requires their consent.

23.35 Children who have sufficient understanding and maturity to enable them to fully understand what is involved in a proposed treatment are considered to be competent (or "Gillick competent") to consent to it. (See Chapter 20).

Treatment without consent – general points

23.36 Although treatment can be provided without a patient's consent if they are detained or liable to be detained according to Articles 21 and 22, consent should still be sought. The patient's consent, refusal to consent, or a lack of capacity to give consent should be recorded in the case notes. If a person has capacity to consent, but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment. A patient is much more likely to adhere to a treatment when discharged from hospital if they consented to its administration at the outset.

23.37 Medical practitioners and staff authorising or administering treatment without consent under the Law are performing a function of a public nature and are therefore subject to the provisions of the Human Rights Law. It is unlawful for them to act in a way which is incompatible with a patient's rights as set out in the Convention.

23.38 In particular, the following should be noted:

- compulsory administration of treatment which would otherwise require consent is invariably an infringement of Article 8 of the ECHR (respect for private and family life). However, it may be justified where it is in accordance with law (in this case the procedures in the Law) and where it is proportionate to a legitimate aim (in this case, the reduction of the risk posed by a person's mental disorder and the improvement of their health)
- compulsory treatment is capable of being inhumane treatment (or in extreme cases even torture) contrary to Article 3 of the ECHR, if its effect on the person concerned reaches a sufficient level of severity. However, the European Court of Human Rights has concluded that a measure which is convincingly shown to be of medical necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading.

23.39 Scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no such incompatibility. If clinicians have concerns about a potential breach of a person's human rights they should seek senior clinical and, if necessary, legal advice.

Treatment plans

23.40 Treatment plans are essential for patients being treated for mental disorder under the Law. A patient's RMO is responsible for ensuring that a treatment plan is in place for that patient.


- 23.41** A treatment plan should include a description of the immediate and long-term goals for the patient and should give a clear indication of the treatments proposed and the methods of treatment.
- 23.42** The treatment plan should form part of a coherent care plan and be recorded in the patient's notes.
- 23.43** Evidence based psychological interventions should be considered as a routine treatment option at all stages, including the initial formulation of a treatment plan and each subsequent review of that plan. Any programme of psychological intervention should form part of the agreed treatment plan and be recorded in the patient's note as such. At no time should it be used as an isolated and spontaneous reaction to particular behaviour.
- 23.44** Wherever possible, the whole treatment plan should be discussed with the patient. Patients should be encouraged and assisted to make use of advocacy support available to them, if they want it. This includes, but need not be restricted to, Independent Mental Health Advocacy services under the Law. Where patients cannot (or do not wish to) participate in discussion about their treatment plan, any views they have expressed previously should be taken into consideration (see Chapter 10).
- 23.45** Subject to the normal considerations of patient confidentiality, the treatment plan should also be discussed with the Nearest Person, with a view to enabling them to contribute to it and express agreement or disagreement.
- 23.46** Discussion with the Nearest Person and/or carers is particularly important where these individuals will themselves be providing care to the patient while the plan is in force. Plans should not be based on any assumptions about the willingness or ability of carers to support patients, unless those assumptions have been discussed and agreed with the carers themselves. Carers have an important role to play in maintaining the patient's contact with home and community life and providing emotional support when the patient is detained. In some cases carers' willingness and ability to contribute to the provision of care may be dependent on additional support and they should be reminded of possible sources of such support and their entitlement to a carer's assessment.
- 23.47** For children and young people, subject to the normal considerations of patient confidentiality, the plan should similarly be discussed with the people who have parental responsibility for them.
- 23.48** Treatment plans should be regularly reviewed and the results of reviews recorded in the patient's notes.
- 23.49** In so far as it deals with decisions about medical treatment for people aged 16 or above who lack capacity to consent to or refuse such treatment, the Capacity Law applies to patients subject to the Law in the same way as to anyone else.

Emergency treatment

23.50 In an emergency, the recall of patients who lack capacity should be considered as it is not permissible to forcibly treat a person/treat the person without their consent in the community.

Decisions of courts not to give treatment

23.51 In certain circumstances, the court may have the power to order that treatment must not be given. Should such an order be made, legal advice should be sought on the legal authority for continuing or starting any such treatment.



Chapter 24: Treatments subject to special rules and procedures

Chapter 24

Definitions.....	189
Treatments requiring consent and a second opinion.....	189
Electro-convulsive therapy.....	190
Treatments requiring either consent or a second opinion.....	190
Urgent cases where certificates are not required.....	191
Requesting a SOAD visit.....	192
Arranging and preparing for SOAD visits.....	193
Statutory Consultation.....	193
The SOAD's decision and reasons.....	194
Status of the certificates for treatment requiring consent.....	196
Review of treatment and withdrawal of approval (Articles 40 and 41).....	196
Other circumstances when certificates cease to be effective.....	197

Chapter 24: Treatments subject to special rules and procedures

24.1 This Chapter gives guidance on the special rules and procedures in the Law for certain types of medical treatment for mental disorder.

Definitions

24.2 In this Chapter:

- “detained patients” means the same as in Chapter 17
- “SOAD” means a second opinion approved doctor as defined in Article 38(3)
- “SOAD certificate” means a certificate issued by a SOAD approving treatment for a particular patient. Such a certificate can be granted for a maximum period of six months.

Treatments requiring consent and a second opinion

24.3 Article 40 applies to neurosurgery for mental disorder, surgical implantation of hormones to reduce male sex drive, ECT and any other treatment prescribed by regulation. It applies to all patients, whether or not they otherwise are subject to the Law.

24.4 Where Article 40 applies, these treatments can be given only if all three of the following requirements are met:

- the patient consents to the treatment
- a SOAD, who shall consult with the patient’s RMO and another professional involved with the patient’s medical treatment certifies that the patient has the capacity to consent and has done so, and
- the SOAD also certifies that it is appropriate for the treatment to be given to the patient.

24.5 A decision to administer treatments to which Article 40 applies requires particularly careful consideration, given their significance and sensitivity.

24.6 Professionals should satisfy themselves that the patient is capable of giving valid consent and is willing to consent. Valid consent is defined in Chapters 28 and 29. The restrictions and procedures imposed by Article 40 should be explained to the patient, and it should be made clear to them that a willingness to receive treatment does not necessarily mean that the treatment will be given.

Electro-convulsive therapy

24.7 Article 40 applies to the administration of Electro-convulsive therapy (ECT) and to medication administered as part of ECT.

24.8 Patients who have the capacity to consent may not be given this treatment unless they do in fact consent. The RMO or a SOAD must certify that the patient has the capacity to consent and has done so.

24.9 A patient who lacks the capacity to consent may not be given treatment under the Law unless a SOAD certifies that the patient lacks capacity to consent and that:

- the treatment is appropriate;
- no valid and applicable advance decision has been made refusing the treatment; and
- the treatment would not conflict with a decision of the court which prevents the treatment being given.

24.10 In all cases, SOADs should indicate on the certificate the maximum number of administrations of ECT which it approves.

24.11 For children and young people aged between 16-17, a SOAD certificate by itself is not sufficient to authorise the treatment; doctors must also have the patient's own consent or an order from the court giving consent on the patient's behalf.

24.12 Patients of all ages to be treated with ECT should be given written information before their treatment starts which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose and likely effects.

Treatments requiring either consent or a second opinion

24.13 Article 41 applies to the administration of medication for mental disorder. However, it only applies once three months have passed from the day on which any form of medication for mental disorder was first administered to the patient during the patient's current period of detention under the Law ("the three month period").

24.14 For these purposes, the patient's current period of detention continues even if the Article under which the patient is detained changes.

24.15 Article 41 applies only to detained patients. They cannot be given medication after the initial three month period to which Article 41 applies unless:

- the RMO or AP in charge of the treatment, or a SOAD, certifies that the patient has the capacity to consent and has done so; or
- a SOAD certifies that the treatment should be given and either that:
 - the patient does not have the capacity to consent; or
 - the patient has the capacity to consent but has refused to do so.

24.16 The manager of the Approved Establishment should ensure that systems are in place to remind both the RMO in charge of the medication and the patient at least four weeks before the expiry of the three-month period.

24.17 Where an RMO or an AP certifies the treatment of a patient who consents, they should not rely on the certificate as the only record of their reasons for believing that the patient has consented to the treatment. A record of their discussion with the patient, and of the steps taken to confirm that the patient has the capacity to consent should be made in the patient's notes as usual.

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

24

Urgent cases where certificates are not required

24.19 Articles 40 and 41 do not apply in urgent cases where treatment is immediately necessary (Article 44).

24.20 This applies only if the treatment in question is immediately necessary to:

- save the patient's life;
- prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed;

- alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard; or
- prevent patients behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.

24.21 These are strict tests. It is not enough for there to be an urgent need for treatment or for the clinicians involved to believe the treatment is necessary or beneficial.

24.22 Urgent treatment under Article 44 can only continue for as long as it remains immediately necessary. If it is no longer immediately necessary, the normal requirements for certificates apply.

24.23 Although certificates are not required where treatment is immediately necessary, the other requirements of Part 9 of the Law still apply. The treatment is not necessarily allowed just because no certificate is required.

24.24 The manager of the Approved Establishment should monitor the use of these exceptions to the certificate requirements to ensure that they are not used inappropriately or excessively. They are advised to provide a form (or other method) by which the RMO in charge of the treatment in question can record the details of:

- the proposed treatment;
- why it is immediately necessary to give the treatment; and
- the length of time for which the treatment is given.

24.25 The data and information utilised in monitoring the use of Articles 44 must be shared with The Administrator. This will in turn be shared with the Minister and may be included in the annual report.

Requesting a SOAD visit

24.26 If a SOAD certificate is required, the RMO in charge of the treatment in question has the professional responsibility of ensuring that the request is made to The Administrator for a SOAD to visit.

24.27 If a RMOs is able to issue a certificate themselves confirming that a patient has consented to treatment, they should do so. Requests to The Administrator to arrange a visit from a SOAD should only be made if they are genuinely unable to determine for themselves whether the patient has the capacity to consent or whether the patient is in fact consenting.

Arranging and preparing for SOAD visits

24.28 SOADs will visit detained patients in Approved Establishment.

24.29 The treatment proposal for the patient, together with notes of any relevant multi-disciplinary discussion on which it was based, must be given to the SOAD before the time of the visit.

24.30 During a visit, SOADs should:

- satisfy themselves that the patient's detention records are in order (where applicable); and
- interview the patient in private if possible. Others may attend if the patient and the SOAD wish, or it is thought that the SOAD would be at risk of significant physical harm from the patient (and the SOAD agrees).

24.31 The manager of the Approved Establishment is responsible for ensuring that people whom the SOAD wishes to meet, including the RMO in charge of the treatment, are available in person at the time the SOAD visits.

24.32 The manager of the Approved Establishment is also responsible for ensuring that all relevant documentation, including the patient's full clinical notes, are available for the SOAD's inspection.

24.33 SOADs have a right to access records without the patient's consent, if necessary, but only those records relating to the treatment of the patient in the Approved Establishment or other establishment in which they are examining the patient.

24.34 Where the proposed treatment includes medication, particularly where the regimen is complex or unusual, the RMOs should undertake or seek pharmacy guidance for a medication review before seeking a SOAD certificate. SOADs should have access to the recent medication review.

24

Statutory Consultation

24.35 SOADs are required to consult two people before issuing certificates approving treatment. This must be the RMO of the patient and a mental health professional who must be concerned with the patient's treatment.

24.36 The second consultee with whom the SOAD proposes to consult should consider whether they are sufficiently concerned professionally with the patient's treatment to fulfil the function. If not, or if a consultee feels that someone else is better placed to fulfil the function, they should make this known to the RMO in charge of the treatment and to the SOAD in good time.

24.37 Statutory consultees may expect to have a private discussion with the SOAD to be listened to with consideration. Among the issues that the consultees should consider commenting on are:

- the proposed treatment and the patient's ability to consent to it;
- their understanding of the past and present views and wishes of the patient;
- other treatment options and the way in which the decision on the treatment proposal was arrived at;
- the patient's progress and the views of the patient's carers; and
- where relevant, the implications of imposing treatment on a patient who does not want it and the reasons why the patient is refusing treatment.

24.38 When the SOAD wishes to speak to the consultees face to face, the Approved Establishment managers should ensure that the SOAD is able to do so.

24.39 Consultees should ensure that they make a record of their consultation with the SOAD, which is then placed in the patient's records.

24.40 SOADs should also be prepared, where appropriate, to consult a wider range of people who are concerned with the patient's care than those required by the Law. That might include the patient's GP and, unless the patient objects, the patient's Nearest Person, parents (where relevant), other family and carers.

The SOAD's decision and reasons

24.41 The SOAD's role is to provide an additional safeguard to protect the patient's rights, primarily by deciding whether certain treatments are appropriate and issuing certificates accordingly. Although approved by the Minister, SOADs act as independent professionals and must reach their own judgement about whether the proposed treatment is appropriate.

24.42 When deciding whether it is appropriate for treatment to be given to a patient, SOADs are required to consider both the clinical appropriateness of the treatment to the patient's mental disorder and its appropriateness in the light of all the other circumstances of the patient's case.

24.43 SOADs should, in particular:

- consider the appropriateness of alternative forms of treatment, not just that proposed;
- balance the potential therapeutic efficacy of the treatment against the side effects and any potential disadvantages to the patient;
- seek to understand the patient's views on the proposed treatment, and the reasons for them;
- give due weight to the patient's views, including any objection to the proposed treatment and any preference for an alternative;
- take into account any previous experience of comparable treatment for a similar episode of disorder; and
- give due weight to the opinions, knowledge, experience and skills of those consulted.

24.44 SOADs must provide written reasons in support of their decisions to approve specific treatments for patients. SOADs do not have to give an exhaustive explanation, but should provide their reasons for what they consider to be the substantive points on which they made their clinical judgement. These reasons can be recorded on the certificate itself when it is given, or can be provided to the RMO of the patient separately as soon as possible afterwards.

24.45 A certificate may be acted on even though the SOAD's reasons have yet to be received. However if there is no pressing need for treatment to begin immediately, it is preferable to wait until the reasons are received, especially if the patient is likely to disagree with the decision.

24.46 When giving reasons SOADs will need to indicate whether, in their view, disclosure of the reasons to the patient would be likely to cause serious harm to the patient's physical or mental health, or to that of any other person.

24.47 It is the professional responsibility of the RMO to communicate the results of the SOAD visit to the patient. This need not wait until any separate statement of reasons has been received from the SOAD. Where a separate statement is received from the SOAD, the patient should be given the opportunity to see it as soon as possible, unless the RMO (or the SOAD) thinks that it would be likely to cause serious harm to the physical or mental health of the patient or any other person.

24.48 Documents provided by SOADs are part of, and should be kept in, the patient's records. The RMO should record their actions in providing patients with (or withholding) the reasons supplied by a SOAD.

- 24.49** Every attempt should be made by the RMO and the SOAD to reach agreement. A generally sound plan need not be rejected as a whole because of a minor disagreement about one aspect of it.
- 24.50** If a SOAD is unable to agree with the RMO, the SOAD should inform the RMO personally as soon as possible. It is good practice for a SOAD to give reasons for such disagreement.
- 24.51** Neither the SOAD nor the RMO should allow a disagreement in any way to prejudice the interests of the patient. If agreement cannot be reached, the position should be recorded in the patient's records by the RMO in charge of the treatment in question.
- 24.52** The opinion given by the SOAD is the SOAD's personal responsibility. There can be no appeal to the Minister against the opinion.

Status of the certificates for treatment requiring consent

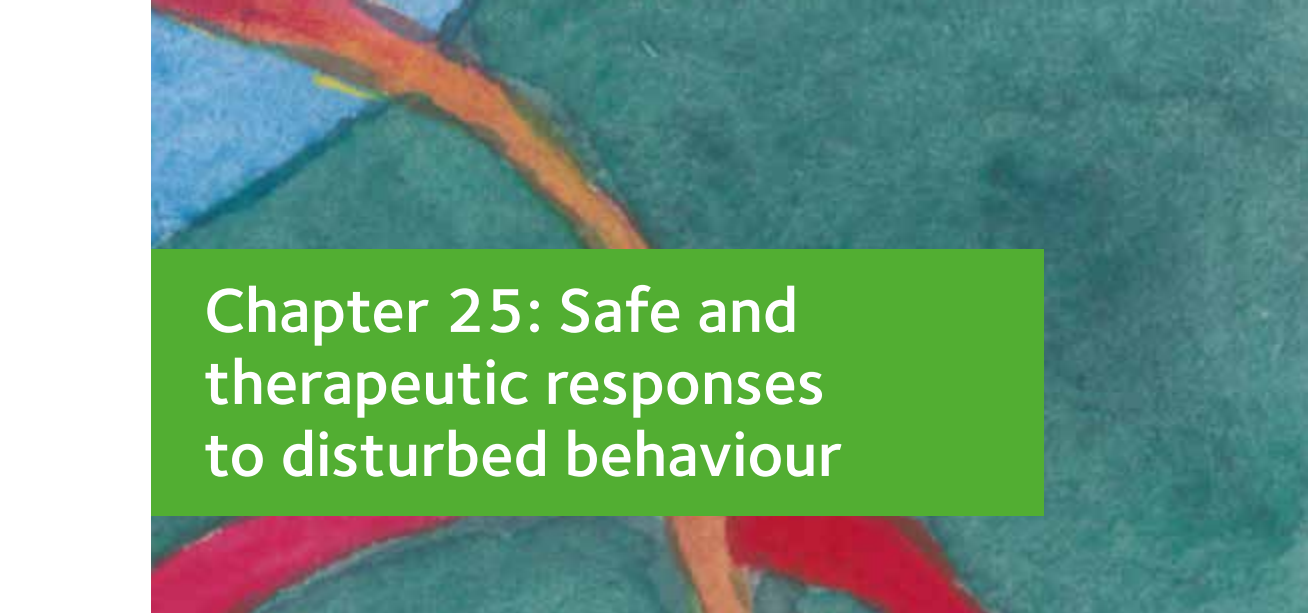
- 24.53** A certificate issued by an AP or by a SOAD is not an instruction to administer treatment.
- 24.54** The fact that the SOAD has authorised a particular treatment does not mean that it will always be appropriate to administer it on any given occasion, or even at all. People administering the treatment, or directing its administration, must still satisfy themselves that it is an appropriate treatment in the circumstances.
- 24.55** They also need to take reasonable steps to assure themselves that the treatment is, in fact, authorised by the certificate, given what is said in the certificate about the patient's capacity and willingness to consent.
- 24.56** Original signed certificates should be kept with the documents which authorise the patient's detention, and copies should be kept in the patient's records. As a matter of good practice, a copy of the certificate relating to medication should also be kept with the patient's medicine chart (if there is one) to minimise the risk of the patient being given treatment in contravention of the provisions of the Law.

Review of treatment and withdrawal of approval (Articles 40 and 41)

- 24.57** Although the Law does not require the validity of certificates to be reviewed after any particular period, it is good practice for the RMO to review them at regular intervals. The purpose of such a review is to ascertain that the patient continues to give consent to treatment where such consent is required. In the event that the patient no longer consents treatment cannot be provided.

Other circumstances when certificates cease to be effective

24.58 There are a number of other circumstances in which a certificate will cease to authorise treatment (or a particular treatment) for example: in such circumstances where the patient no longer consents to treatment or no longer has the capacity to consent to treatment. People administering treatment on the basis of a certificate should always take reasonable steps to satisfy themselves that the certificate remains applicable to the circumstances.



Chapter 25: Safe and therapeutic responses to disturbed behaviour

Chapter 25

Restrictive intervention reduction programmes	199
Provider protocols and guidelines	200
Individualised assessments	201
Primary, secondary and tertiary strategies	203
Meeting needs.....	204
Respecting human rights.....	210
Children and young people under 18	211

Chapter 25: Safe and therapeutic responses to disturbed behaviour

- 25.1** A safe and therapeutic culture should be provided for all people receiving treatment for a mental disorder including those who may present with behavioural disturbance.
- 25.2** This Chapter provides guidance for providers, professionals and practitioners on how to manage people with disturbed behaviour which may present a particular risk to themselves or to others, including those charged with their care. It requires providers to have restrictive intervention reduction programmes and associated protocols or policies in situ. Chapters 31 and 32 make clear that restrictive interventions such as: enhanced observation, physical restraint, mechanical restraint, rapid tranquillisation, seclusion and long-term seclusion, should only be used in a way that respects human rights. It provides guidance on individualised assessments, as well as care plans or treatment plans which include primary, secondary and tertiary strategies (in some services such care plans are referred to as positive behavioural support (PBS) plans). It provides a definition of restrictive intervention and gives guidance on particular types of restrictive interventions. Guidance is also given on the particular needs of children and young people and on the importance of appropriate staff training.
- 25.3** Except where otherwise stated, this guidance applies to all people receiving treatment for a mental disorder in a hospital and who are liable to present with behavioural disturbances, regardless of their age and whether or not they are detained under the Law.

Restrictive intervention reduction programmes

- 25.4** Providers who treat people who are liable to present with behavioural disturbances should focus primarily on providing a positive and therapeutic culture. This culture should aim at preventing behavioural disturbances, early recognition, and de-escalation.

25.5 Providers should have governance arrangements in place that enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive interventions. When restrictive interventions are unavoidable, providers should have a robust approach to ensuring that they are used in the safest possible manner. All mental health providers therefore should have in place a regularly reviewed and updated restrictive intervention reduction programme.

25.6 Restrictive intervention reduction programmes are overarching, multi-component action plans which aim to reduce the use of restrictive interventions. They should demonstrate organisational commitment to restrictive intervention reduction at a senior level, how the use of data relating to restrictive interventions will inform service developments, continuing professional development for staff, how models of service which are known to be effective in reducing restrictive interventions are embedded into care pathways, how service users are engaged in service planning and evaluation and how lessons are learned following the use of restrictive interventions. They should ensure accountability for continual improvements in service quality through the delivery of positive and proactive care.

They should also include improvement goals and identify who is responsible for progressing the different parts of the plan. A key indicator that a plan is being delivered well will be a reduction in the use of restrictive interventions. Other indicators include reduction of injuries as a result of restrictive interventions, improved patient satisfaction and reduced complaints.

Provider protocols and guidelines

25.7 Restrictive interventions may be required in health and social care settings as part of a broader therapeutic programme. When they are required, they should be planned, evidence based, lawful, in the patient's interests, proportionate and dignified. In order to ensure that this is the case, each provider should have one or more policies that guide the day-to-day operation of services ('provider protocols'), which should include guidance on:

- assessments of risks and support needs
- the use of positive behaviour support plans (or equivalent)
- how the risks associated with restrictive interventions can be minimised; in particular, an assessment of their potential to cause harm to the physical, emotional and psychological wellbeing of patients and how providers will take account of a patient's individual vulnerabilities to harm (such as unique needs associated with physical/emotional immaturity, older age, disability, poor physical health, pregnancy, past history of traumatic abuse etc)

- how restrictive interventions which are used by the provider, should be authorised, initiated, applied, reviewed and discontinued, as well as how the patient should be supported throughout the duration of the application of the restrictive intervention
- local recording and reporting mechanisms around the use of restrictive interventions
- post-incident analysis/debrief, and
- workforce development, including training requirements relating to the application of restrictive interventions, which are underpinned by their therapeutic intent.

Individualised assessments

- 25.8** People suffering from a mental disorder should, on admission to hospital, be assessed for immediate and potential risks of behavioural disturbance. Staff should be alert to risks that may not be immediately apparent, such as self-neglect. Assessments should take account of the person's history of such behaviours, their history of experiencing personal trauma, their presenting mental and physical state and their current social circumstances.
- 25.9** While previous history is an important factor in assessing current risk, staff should not assume that a previous history of behavioural disturbance means that a person will necessarily behave in the same way in the future. Additionally, consideration should be made as to whether 'history' is genuinely evidence-based and supported by actual recordings. Anecdotal information which is not evidenced should not form part of decision-making.
- 25.10** Care should be taken to ensure that negative and stigmatising judgements about certain diagnoses, behaviours or personal characteristics do not obscure a rigorous assessment of the degree of risk which may be presented, or the potential benefits of appropriate treatment to people who are assessed as liable to present with behavioural disturbance. Providers should consider the accuracy of assessments of risks as part of routine audit arrangements and put training in place to learn from any inappropriate risk judgements. Cultural awareness is particularly important in understanding behaviour and responding appropriately; assessments should be carried out in a way that takes account of any cultural issues.
- 25.11** Assessments of behavioural presentation are important in understanding an individual's needs. These should take account of the individual's social and physical environment and the broader context against which behavioural disturbance occurs. There may be times where an individual feels angry for reasons not associated with their mental disorder and this may be expressed as behavioural disturbance. Assessments should seek to understand behaviour in its broader context and not presume it to be a manifestation of a mental disorder.

- 25.12** Assessments should consider the views of patients and their families, carers and advocates about why an individual might be behaving in a particular way, including any historical accounts of behaviour and possible reasons for that behaviour. This is particularly important because they can provide useful insights regarding individual responses to interventions that have been tried in the past.
- 25.13** The results of the assessment should guide the development and implementation of effective, personalised and enduring systems of support that meet an individual's needs, promote recovery and enhance quality of life outcomes for the individual and others who care and support them.
- 25.14** When concluded, assessments should describe behaviours of concern, identify factors which predict their occurrence, and describe the functions that behaviours serve or the outcomes they achieve for the individual. These assessments should inform the patient's care plan and/or positive behaviour support plans (or equivalent).

Factors which may contribute to behavioural disturbance and which should be considered within assessments include:

- poorly treated symptoms of mental disorder
- unmet social, emotional or health needs
- excessive stimulation, noise and general disruption
- excessive heating, overcrowding and restricted access to external space
- boredom, lack of constructive things to do, insufficient environmental stimulation
- lack of clear communication by staff with patients
- the excessive or unreasonable application of demands and rules
- lack of positive social interaction
- restricted or unpredictable access to preferred items and activities
- patients feeling that others (whether staff, friends and/or families) are not concerned with their subjective anxieties and concerns
- exposure to situations that mirror past traumatic experiences
- a sense of personal disempowerment
- emotional distress, e.g. following bereavement
- frustrations associated with being in a restricted and controlling environment

- antagonism, aggression or provocation on the part of others
- inconsistent care
- difficulties with communication
- the influence of alcohol or drugs
- a state of confusion, and
- physical illness.

Primary, secondary and tertiary strategies

25.15 Staff should ensure that patients who are known to present with behavioural disturbance have a care or treatment plan which includes primary preventative strategies, secondary preventative strategies and tertiary strategies. In some services such a care or treatment plan is referred to as a positive behaviour support plan. These individualised care plans, should be available and kept up to date, and include the following elements:

- primary preventative strategies aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbances
- secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to encourage the patient to be calm, and
- tertiary strategies guide the responses of staff and carers when there is a behavioural disturbance. Responses should be individualised and wide ranging, if appropriate, possibly including continued attempts to de-escalate the situation, summoning assistance, removing sources of environmental stress or removing potential targets for aggression from the area. Where it can reasonably be predicted on the basis of risk assessment, that the use of restrictive interventions may be a necessary and proportionate response to behavioural disturbance, there should be clear instruction on their pre-planned use. Instructions should ensure that any proposed restrictive interventions are used in such a way as to minimise distress and risk of harm to the patient.

25.16 Patients and their families should be as fully involved as possible in developing and reviewing positive behaviour support plans (or equivalents). Patients eligible for support from an IMHA should be reminded that an IMHA can support them in presenting their views and discussing their positive behaviour support plan (or equivalent). The preparation of positive behaviour support plans (or equivalents) also provides an important opportunity to record the wishes and preferences

of families and carers and the involvement they may wish to have in the management of behavioural disturbances. For example, on occasion, family members may wish to be notified if the patient is becoming anxious and to contribute to efforts to de-escalate the situation by speaking to the individual on the phone. People must consent to the involvement of families or advocates if they have capacity to give or refuse such consent.

- 25.17** Positive behaviour support plans (or equivalent) should take account of disabilities, a patient's level of cognitive functioning, the impact of age in terms of physiological and emotional maturity, the patient's ethnicity, culture, religion or belief, gender, gender identity and sexual identity. They should maximise privacy and dignity.

Meeting needs

Primary preventative strategies

- 25.18** Behavioural disturbance can be minimised by promoting a supportive and therapeutic culture within the care environment. Unless an individual is subject to specific justifiable restrictions (e.g. for security reasons), primary preventative strategies should typically include the following, depending on the individual's assessed needs:

A: The care environment:

- providing predictable access to preferred items and activities
- avoiding excessive levels of environmental stimulation
- organising environments to provide for different needs, for example, quiet rooms, recreation rooms, single-sex areas and access to open spaces and fresh air
- providing each patient with a defined personal space and a safe place to keep their possessions
- ensuring an appropriate number and mix of staff to meet the needs of the patient population
- ensuring that reasonable adjustments can be made to the care environment to support people whose needs are not routinely catered for, for example, sensory impairments, and
- avoiding demands associated with compliance with service-based routines and adherence to 'blanket rules'.

B: Engaging with individuals and their families:

- ensuring that individuals are able to meet visitors safely in private and convivial environments, as well as to maintain private communication by telephone, post and electronic media, respecting the wishes of patients and their visitors
- engaging individuals, supporting them to make choices about their care and treatment and keeping them fully informed, and communicating in a manner that ensures the individual can understand what is happening and why
- involving individuals in the identification of their own trigger factors and early warning signs of behavioural disturbance and in how staff should respond to them
- engaging individuals in all aspects of care and support planning
- ensuring that meetings to discuss an individual's care occur in a format, location and at a time of day that promotes engagement of patients, families, carers and advocates
- with the individual's consent (if they have the capacity to give or refuse such consent), involving their nearest relative, family, carers, advocates and others who know them and their preferences in all aspects of care and treatment planning, and
- promptly informing patients, families, carers and advocates of any significant developments in relation to the individual's care and treatment, wherever practicable and subject to the patient's wishes and confidentiality issues.

C: Care and support:

- opportunity for individuals to be involved in decisions about an activity and therapy programme that is relevant to their identified needs, including evening and weekend activities
- delivering individualised patient-centred care which takes account of each person's unique circumstances, their background, priorities, aspirations and preferences
- supporting individuals to develop or learn new skills and abilities by which to better meet their own needs
- developing a therapeutic relationship between patients and staff, including the appointing of a Care Coordinator identified as the patient's primary contact at the service

- providing training for staff in the management of behavioural disturbance, including alternatives to restrictive interventions, desirable staff attitudes and values, and training in the implementation of models of care including positive behavioural support plans
- ensuring that individuals' complaints procedures are accessible and available and that concerns are dealt with quickly and fairly
- ensuring that physical and mental health needs are holistically assessed and that the person is supported to access the appropriate treatments, and
- developing alternative coping strategies in response to known predictors of behavioural disturbance

25.19 People who are identified as being at risk of presenting with behavioural disturbance should be given the opportunity to have their wishes and feelings recorded in an Advance Statement, if they have the capacity to do so.

25.20 Whilst some psychological treatments or programmes may impose restrictions on normal day-to-day activities (e.g. restricting access to favoured activities or incentives so that they are available only as incentives or behavioural re-enforcers), such restrictions should not be imposed across the service, or be used punitively. This means that service providers should avoid blanket restrictions that apply to all patients; interventions should always be individualised, and subject to discussion and review by the whole clinical team. The individual's consent to the intervention should always be sought where the individual has capacity to consent or refuse the intervention, even if a refusal may be overridden (e.g. because it is part of the compulsory treatment the individual may be given under the Law).

25.21 Restrictions associated with such programmes should be reasonable and proportionate to the risks associated with the behaviour being addressed and consistent with the guiding principles of the Code (and the Capacity Law where it applies). Access to leave, food and drink, fresh air, shelter, warmth, a comfortable environment, exercise, confidentiality or reasonable privacy should never be restricted or used as a reward or privilege dependant on desired behaviours.

25.22 Psychological treatments with the goal of behavioural change should only be used under the direct supervision of a suitably trained and competent professional, and should be monitored regularly for impact.

25.23 Provider policies should encourage patients to avoid staying in their bedrooms for prolonged periods during the daytime. Therapeutic interventions and a range of engaging activities should be available and people should not be locked out of their bedrooms in an attempt to restrict their freedom of movement.

Secondary preventative strategies

- 25.24** De-escalation is a secondary preventative strategy. It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance.
- 25.25** De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.
- 25.26** Staff should liaise with individuals and those who know them well, and take into account clinical assessments, to identify individualised de-escalation approaches which should be recorded as secondary preventative strategies in the individual's positive behaviour support plan (or equivalent). In some instances it may be feasible for families to contribute to de-escalation approaches, e.g. by speaking to their relative on the telephone.
- 25.27** Staff should ensure that they do not exacerbate behavioural disturbance, e.g. by dismissing genuine concerns or failing to act as agreed in response to requests, or through the individual experiencing unreasonable or repeated delays in having their needs met. Where such failures are unavoidable, every effort should be made to explain the circumstances of the failure to the individual and to involve them in any plans to redress the failure.

Enhanced observation

- 25.28** Staff should know the location of all patients for whom they are responsible in a hospital ward or service. It is not necessary to routinely keep patients who are not considered to present a serious risk of harm to themselves or others within sight.
- 25.29** Research suggests that most attempted suicides are discovered and prevented by staff checking on patients, particularly in the more private areas of wards. For individuals assessed as being at risk of suicide or serious self-harm, a significant preventive mechanism is for nursing staff to be caringly vigilant and inquisitive. For such individuals, staff should have a thorough knowledge of the patient and have a clear plan in relation to monitoring and supervision. Unusual circumstances and noises should be investigated.

- 25.30** There may be times when enhanced levels of observation are required for the short-term management of behavioural disturbance or during periods of distress to prevent suicide or serious self-harm. Enhanced observation is a therapeutic intervention with the aim of reducing the factors which contribute to increased risk and promoting recovery. It should focus on engaging the person therapeutically and enabling them to address their difficulties constructively (e.g. through sitting, chatting, encouraging/supporting people to participate in activities, to relax, to talk about any concerns etc.).
- 25.31** Enhanced observation may be provided on an intermittent basis with staff engaging with patients and observing their condition at irregular and unpredictable intervals of between 15 and 30 minutes.
- 25.32** Alternatively enhanced observation may be provided on a continuous basis with the individual remaining either within eyesight of staff or, for the most serious degrees of risk, within arm's length. Continuous observation should be carried out when intermittent observation is seen as insufficient to safely manage risks.
- 25.33** Provider policies should cover the use of enhanced observation and include:

- which staff (profession and grade) are best placed to carry out enhanced observation and under what circumstances it might be appropriate to delegate this duty to another member of the team
- how the selection of a staff member to undertake enhanced observation should take account of the individual's characteristics and circumstances (including factors such as ethnicity, sexual identity, age and gender)
- how enhanced observation can be undertaken in a way which minimises the likelihood of individuals perceiving the intervention to be coercive, and
- how observation can be carried out in a way that respects the individual's privacy as far as practicable and minimises any distress. In particular, provider policies should outline how an individual's dignity can be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing, showering, dressing etc.

- 25.34** Staff should balance the potentially distressing effect on the individual of increased levels of observation, particularly if these are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance. Levels of observation and risk should be regularly reviewed and a record made of decisions agreed in relation to increasing or decreasing the observation.

Restrictive interventions

25.35 Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and
- end or reduce significantly the danger to the patient or others.

25.36 Where a person restricts a patient's movement, or uses (or threatens to use) force then that should:

- be used for no longer than necessary to prevent harm to the person or to others
- be a proportionate response to that harm, and
- be the least restrictive option.

25.37 Where risk assessments identify that restrictive interventions may be needed, their implementation should be planned in advance and recorded as tertiary strategies within the positive behaviour support plans (or equivalent).

25.38 On other occasions, behavioural disturbance may not have been predicted by risk assessments. In such cases emergency management of the situation and the use of restrictive interventions should be based on clinical judgement which take account of relevant best practice guidance (such as those published by the National Institute for Health and Care Excellence (NICE)), and all available knowledge of the patient's circumstances.

25.39 The most common reasons for needing to consider the use of restrictive interventions are:

- physical assault by the patient
- dangerous, threatening or destructive behaviour
- self-harm or risk of physical injury by accident
- extreme and prolonged over-activity that is likely to lead to physical exhaustion, or
- attempts to escape or abscond (where the patient is detained under the Law or deprived of their liberty under the Capacity Law).

25.40 Restrictive interventions should be used in a way that minimises any risk to the patient's health and safety and that causes the minimum interference to their autonomy, privacy and dignity, while being sufficient to protect the patient and other people. The patient's freedom should be contained or limited for no longer than is necessary.

25.41 The choice and nature of restrictive intervention will depend on various factors, but should be guided by:

- the patient's wishes and feelings, if known (e.g. by an Advance Statement)
- what is necessary to meet the needs of the individual based on a current assessment and their history
- the patient's age and any individual physical or emotional vulnerabilities that increase the risk of trauma arising from specific forms of restrictive intervention
- whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear
- obligations to others affected by the behavioural disturbance
- responsibilities to protect other patients, visitors and staff, and
- the availability of resources in the environment of care.

25.42 Where an individual has a history of abuse, restrictive interventions of any nature can trigger responses to previous traumatic experiences. Responses may be extreme and may include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression. Where patients have an identified history of trauma it will be particularly useful to obtain their recorded wishes about restrictive interventions. Patients' preferences in terms of the gender of staff carrying out such interventions should be sought and respected.

25.43 Providers should work with local police services to establish clear local protocols about the circumstances when, very exceptionally, the police may be called to manage patient behaviour within a health or care setting. In these cases, mental health professionals continue to be responsible for the health and safety of the person. Health staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the patient's physical and psychological wellbeing.

Respecting human rights

25.44 Any use of restrictive interventions must be compliant with the Human Rights Law, which gives effect in Jersey to certain rights and freedoms guaranteed under the Convention.

- 25.45** Services and their staff should help all patients to understand the legal authority for any proposed action and their rights (especially their right to leave a hospital if they are not detained there). Informal patients should, in particular, be informed of the existence of holding powers.
- 25.46** No restrictive intervention should be used unless it is medically necessary to do so in all the circumstances of the case. Action that is not medically necessary may well breach a patient's rights under Article 3 of the ECHR, which prohibits inhuman or degrading treatment.
- 25.47** Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for Article 3 of the ECHR may nevertheless breach Article 8 of the ECHR if it has a sufficiently adverse effect on the patient's private life, including their moral and physical integrity.
- 25.48** Restrictions that alone, or in combination, deprive a patient of their liberty without lawful authority will breach Article 5 of the ECHR (the right to liberty). There is a significant restriction on liberty in circumstances where a person is under continuous control and supervision and is not free to leave and lacks capacity to consent to the proposed interventions giving rise to the significant restriction on liberty. However, the precise scope of the term 'significant restriction on liberty' is not fixed and will develop over time in accordance with changes in European and UK case law as well as developments in case law in Jersey.
- 25.49** Unless a patient is detained under the Law or is subject to a significant restriction on liberty authorisation or court order under the Capacity Law, providers and their staff must be careful to ensure that the use of restrictive interventions does not impose restrictions which amount to a significant restriction on liberty.
- 25.50** Examples of restrictions that could indicate there is a significant restriction on liberty include:

- informal patients being prevented from leaving a hospital
- informal patients being told that they will be detained under the Law if they do not comply with requests of staff, or
- informal patients being kept in circumstances amounting to seclusion without their consent.

Children and young people under 18

- 25.51** In the case of children and young people under the age of 18, the use of restrictive interventions may require modification to take account of their developmental status. The legal context within which restrictive interventions are used with children and young people is different from adults; key aspects of this are explored in the following paragraphs.

- 25.52** Service providers should ensure that staff involved in the care of children and young people who exhibit behavioural disturbance are able to employ a variety of skills and strategies that enable them to provide appropriate help and support. In most cases restrictive interventions will only be used if they form part of the positive behaviour support plan (or equivalent) and have therefore been developed with input from the child or young person and their family.
- 25.53** Staff should always ensure that restrictive interventions are used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.
- 25.54** When antipsychotic medication is used to sedate a child or young person, special consideration should be given to risks relating to their developing central nervous system, especially when the medication is given to children or adolescents who do not have a diagnosed psychosis.
- 25.55** The size and physical vulnerability of children and young people should be taken into account when considering physical restraint. Physical restraint should be used with caution when it involves children and young people because in most cases their musculoskeletal systems are immature which elevates the risk of injury.
- 25.56** Seclusion can be a traumatic experience for any individual but can have particularly adverse implications for the emotional development of a child or young person. This should be taken into consideration in any decision to seclude a child or young person. Careful assessment of the potential effects of seclusion by a trained child and adolescent clinician is required, especially for those children and adolescents with histories of trauma and abuse, where other strategies to de-escalate behaviours may be more appropriate than the use of seclusion.
- 25.57** In children and young people's services where time-out processes are used, provider policies should differentiate between time-out and seclusion. Time-out is a specific behaviour change strategy which should be delivered as part of a behavioural programme. Time-out might include: preventing a child or young person from being involved in activities which reinforce a behaviour of concern until the behaviour stops; asking them to leave an activity and return when they feel ready to be involved and stop the behaviour; or accompanying the child or young person to another setting and preventing them from engaging in the activity they were participating in for a set period of time. If time-out processes have the features of seclusion, this should be treated as seclusion and comply with the requirements of the Code.

- 25.58** Restrictive interventions must be used with great caution when applied with children and young people who are not detained under the Law. If there are indications that the use of restrictive interventions (particularly physical restraint or seclusion) might become necessary, consideration should be given to whether formal detention under the Law is appropriate. A person with parental responsibility can consent to the use of restrictive interventions where a child lacks competence or a young person lacks the capacity to consent, but only if the decision falls within the scope of parental responsibility (refer to Chapter 20).
- 25.59** For young people aged 16 or 17 who are not detained under the Law and who lack capacity to consent to the proposed interventions, the use of restrictive interventions in the young person's best interests will not be unlawful if they meet the requirements in Part 5 of the Capacity Law and do not amount to a significant restriction on liberty.
- 25.60** Staff having care of children and young people should adhere to the principle that the welfare of the child is paramount. Therefore they should consider what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare. Whether an intervention is reasonable or not will depend, among other things, upon the urgency and gravity of what is required. This might permit action to be taken to prevent a child from harming themselves, however it would not allow restrictive interventions that are not proportionate and would not authorise actions that amounted to a significant restriction on liberty.



Chapter 26: Restrictive interventions

Chapter 26

Procedures for the safe use of restrictive interventions	215
Physical restraint	217
Mechanical restraint	218
Patients subject to a court order	219
Rapid tranquillisation	219
Seclusion	221
Procedure for seclusion	223
Further guidance on seclusion	227
Long-term seclusion	228
Significant restriction on access to normal daytime clothing	230
Following acute behavioural disturbance	231
Patients subject to Guardianship	232
Training	232
Security assessments	233

Chapter 26: Restrictive Interventions

26.1 This Chapter is an extension of the previous Chapter and should be read and applied in conjunction with it. The purpose of this Chapter is to clearly set out the principles which underpin the use of restrictive intervention and to guide practice in relation to such interventions.

Procedures for the safe use of restrictive interventions

26.2 Provider policies concerning the use of restrictive interventions and their implementation should be kept under ongoing review in order to ensure consistency with best practice guidance and evidence.

26.3 Wherever possible, the use of restrictive interventions must be avoided. As an alternative measures should be taken which may include:

- the adaptation of environments
- the employment of specific approaches by staff which reflect those described in a patient's care plan (as a means of effecting preventative approaches to challenging behaviour)
- the use of de-escalation strategies.

26.4 Restrictive interventions should never be employed to be deliberately punitive.

26.5 Any initial attempt to manage an acute behavioural disturbance should, as far as the situation allows, be non-restrictive. For example, assistance might be sought using an emergency alarm system or by verbally summoning assistance. A single member of staff should assume control of the incident.

26.6 Conflict management approaches should be utilised in a format to suit the communication and cognitive level of the person. Active listening approaches should be considered as a means of demonstrating empathy, a recognition that the patient is unhappy and an acknowledgement that staff members do not seek to enter into a situation of conflict with the patient.

- 26.7** An individual's communication needs should be taken into account including those arising from sensory impairments, learning disability and autism spectrum disorders.
- 26.8** Where other attempts to engage the patient are unsuccessful, the patient may be asked to stop the behaviour. Where possible, an explanation should be given of the consequences of refusing the request from staff to stop the behaviour. The explanation should be provided calmly and every attempt should be made to avoid the explanation being perceived by the patient as a threat.
- 26.9** In the event that restrictive interventions are utilised, the nature and manner of application of any restrictive intervention, the reason(s) for its use and the consequences or outcome, should be recorded in an open and transparent manner.
- 26.10** Staff should only use methods of restrictive interventions for which they have received training. Training records should record precisely the techniques for which a member of staff has received training. Consideration should be made of how and where training records are stored in order that they may be reviewed regularly and consistently.
- 26.11** It is acknowledged that there may be rare occasions where staff members may be compelled to act outside of the extent of the training which they have received. Such circumstances would relate to situations of extremely high risk where there is a danger to self or others. In such circumstances, a serious incident must be recorded leading to an appropriate corporate response in line with local policy.
- 26.12** Verbal de-escalation should continue throughout a restrictive intervention. Alternatively, gestural or visual de-escalation may be used in situations where the patient is non-verbal or otherwise unable to understand the language of the staff member/s. Negotiations should focus on establishing rapport, demonstrating concern, helping the patient to relax, and reducing the patient's level of agitation.
- 26.13** Whenever restrictive interventions are being used, provider's policies should make provision for the timely attendance of a doctor in response to staff requests concerning a psychiatric emergency whether in relation to medication, restraint or seclusion.
- 26.14** Where a behavioural disturbance occurs and a restrictive intervention has been used, family members should be informed in accordance with any prior agreements.

Physical restraint

- 26.15** Physical restraint refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person.
- 26.16** Patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage and/or abdomen. Unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor. Similarly the use of seated restraint should be avoided where possible on account of possible impact upon a patient's airway.
- 26.17** Full account should be taken of the individual's age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the individual's health, safety and wellbeing in the face of exposure to physical restraint. Throughout any period of physical restraint:

- a member of staff should monitor the individual's airway and physical condition to minimise the potential of harm or injury. Observations, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/discolouration), should be conducted and recorded. Staff should be trained so that they are competent to interpret these vital signs
- emergency resuscitation devices should be readily available in the area where restraint is taking place, and
- a member of staff should take the lead in caring for other patients and moving them away from the area of disturbance

26.18 Where physical restraint has been used, staff should record the decision and the reasons for it, including details about how the intervention was implemented and the patient's response.

26.19 If an individual is not detained under the Law, but physical restraint of any form is necessary, consideration should be given to whether the criteria in Part 5 of the Capacity Law apply and/or whether detention under the Law is appropriate (subject to the criteria being met).

26.20 Provider policies concerning the use of physical restraint should be kept under ongoing review in order to ensure consistency with national policy and best practice.

Mechanical restraint

- 26.21** Mechanical restraint is a form of restrictive intervention that refers to the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.
- 26.22** Mechanical restraint should only be used exceptionally, where other forms of restriction cannot be safely employed. It must only be used in line with the principle of least restrictive option and should not be an unplanned response to an emergency situation.
- 26.23** Mechanical restraint should never be used instead of adequate staffing.
- 26.24** The use of mechanical restraint should be approved following multi-disciplinary consultation (which should include an IMHA where the patient has one). The nature of the multi-disciplinary team should be defined in a provider's policies. Provision for the use of mechanical restraint should be recorded as a tertiary strategy in the positive behaviour support plan (or equivalent). This plan should detail the circumstances which might warrant mechanical restraint, the type of device to be applied, how continued attempts should be made to de-escalate the situation and any special measures that are required to reduce the likelihood of physical or emotional trauma resulting.
- 26.25** Where the agreed provisions for the use of mechanical restraint in positive behaviour support plans (or equivalent) allow a nurse or other professional to authorise the actual use of mechanical restraint, then that professional should notify, without delay, the RMO or on-call doctor (or equivalent).
- 26.26** Staff applying mechanical restraint devices should have appropriate training in their application and use.
- 26.27** An individual who is mechanically restrained should remain under continuous observation throughout. It may be necessary for the individual to remain at arm's length.
- 26.28** The individual should be reviewed by a nurse every fifteen minutes for the duration of the period of mechanical restraint.
- 26.29** The individual should have a medical review by a registered medical practitioner at least one hour after the beginning of mechanical restraint. Subsequently there should be ongoing medical reviews at least every four hours by a registered medical practitioner. Local policies should determine which of their registered medical practitioners should undertake medical reviews. Reviews should be undertaken more frequently if requested by nursing staff. Reviews should ensure that the individual is as comfortable as possible and should include a full evaluation of the patient's physical and mental health condition.

- 26.30** Procedures should be in place to enable nursing staff to summon a doctor to conduct a medical review ahead of the next scheduled review if they have concerns about the patient's condition.
- 26.31** The patient's clinical record should provide details of the rationale for the decision to mechanically restrain them, the medical and psychiatric assessment, the patient's condition at the beginning of mechanical restraint, the response to mechanical restraint and the outcomes of the medical reviews.
- 26.32** There may be circumstances where mechanical restraint devices need to be used on a long-term basis, such as to limit frequent and intense self-injurious behaviour. This will be rare and encountered with small numbers of patients who have severe cognitive impairments, where devices such as arm splints or cushioned helmets may be required to safeguard an individual from the hazardous consequences of their behaviour. In such cases, tertiary strategies within positive behaviour support plans (or equivalent) should aim to provide brief recurrent periods when restraints can be removed. The positive behaviour support plan (or equivalent) may also allow for less frequent medical and nursing reviews provided that the whole clinical team, the patient's family, carers and advocates are in agreement.

Patients subject to a court order

- 26.33** There may be occasions when the use of mechanical restraint (including handcuffs) is required for security purposes when transferring prisoners by the police or prison staff, into a healthcare setting.
- 26.34** Similarly, there may be occasions where mechanical restraint (including handcuffs) may be used for security purposes for the transfer of restricted patients in secure settings to non-secure settings. The use of mechanical restraint in these circumstances should be informed by an assessment of the risks posed by the patient, as well as their presenting physical and mental condition and the need to maximise their dignity. Escorting staff should alert medical staff to any identified risks if restraints were to be removed; however, if requested by medical staff, they should be removed whilst medical treatment is carried out.
- 26.35** On occasion, in high-risk cases, the court may grant permission for a restricted patient to leave hospital conditional on the use of restraint.

Rapid tranquillisation

- 26.36** Rapid tranquillisation refers to the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. This may provide an important opportunity for a thorough psychiatric examination to take place.

Prescribers should aim to ensure that the degree of sedation arising from rapid tranquillisation does not compromise the patient's capacity to understand and respond to what is said to them. Such treatment should only take place in a hospital setting. If such treatment is being considered outside of a hospital setting, this is likely to indicate that admission to hospital is required.

- 26.37** Rapid tranquillisation may also be used to manage acute behavioural disturbance, though this should be a very short-term strategy designed solely to reduce immediate risk and is distinct from treating any underlying mental illness.
- 26.38** Rapid tranquillisation should only be used where a patient is highly aroused, agitated, overactive and aggressive, or is making serious threats or gestures towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour.
- 26.39** Rapid tranquillisation includes the use of both intra-muscular injections and oral medication. Oral medication should always be considered before any injections.
- 26.40** Rapid tranquillisation should be prescribed in accordance with evidence-based practice guidelines such as those published by NICE and the Maudsley Prescribing Guidelines in a manner that is consistent with General Medical Council's good practice in prescribing and managing medicines. It must be in line with legal requirements (in respect of patients subject to the Law, the rules concerning treatment and emergency treatment powers under the Law).
- 26.41** Staff prescribing rapid tranquilisation should note any physical observations and monitoring needed following administration and make that clear to staff caring for the patient.
- 26.42** Where a prescription indicates a choice of administration routes for rapid tranquillisation (e.g. oral or intramuscular injection), the person prescribing the medication should list factors which should be considered in deciding which route to use under any reasonably foreseeable circumstances.
- 26.43** Where rapid tranquilisation in the form of an intramuscular injection is needed, the person prescribing the injection should state the preferred injection site, having taken full account of the need to avoid prone restraint (i.e. where the person is forcibly laid on their front).
- 26.44** Physical restraint may, on occasion, need to be used to administer rapid tranquillisation by intramuscular injection to an unwilling patient, where the patient may lawfully be treated without consent. It must not be used unless there is such legal authority, whether under the Law, the Capacity Law or otherwise. Rapid tranquillisation must not be used to treat an informal patient who has the capacity to refuse treatment and who has done so.

- 26.45** The use of restraint to administer treatment in non-emergency circumstances should be avoided wherever possible, but may sometimes be necessary, especially if an emergency situation would be likely to occur if the treatment were not administered. The decision to use restraint should be discussed first with the clinical team and should be properly documented and justified in the patient's notes.
- 26.46** Following the administration of rapid tranquillisation, the patient's condition and progress should be closely monitored. Subsequent records should indicate the reason for the use of rapid tranquillisation and provide a full account of both its efficacy and any adverse effects observed or reported by the patient.
- 26.47** Rapid tranquillisation should never be used to manage patients as a substitute for adequate staffing.

Seclusion

- 26.48** Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.
- 26.49** If a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded and the use of any local or alternative terms (such as 'therapeutic isolation') or the conditions of the immediate environment do not change the fact that the patient has been secluded. It is essential that they are afforded the procedural safeguards of the Code.
- 26.50** Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward. Seclusion does not include locking people in their rooms at night.
- 26.51** Seclusion should only be used in hospitals and in relation to patients detained under the Law. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Law should be undertaken immediately.
- 26.52** Seclusion should never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion should be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety arising from their own self-harm and that any such risk can be properly managed.

26.53 The following factors should be taken into account in the design of rooms or areas where seclusion is to be carried out:

- the room should allow for communication with the patient when the patient is in the room and the door is locked, e.g. via an intercom
- rooms should include limited furnishings which should include a bed, pillow, mattress and blanket or covering
- there should be no apparent safety hazards
- rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
- rooms should have externally controlled lighting, including a main light and subdued lighting for night time
- rooms should have robust door(s) which open outwards
- rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
- rooms should not have blind spots and alternate viewing panels should be available where required
- a clock should always be visible to the patient from within the room, and
- rooms should have access to toilet and washing facilities

26.54 Provider policies should include detailed guidance on the use of seclusion and should be consistent with the guiding principles of the Code. The policy should:

- ensure the physical and emotional safety and wellbeing of the patient
- ensure that the patient receives the care and support rendered necessary by their seclusion both during and after it has taken place
- designate a suitable environment that takes account of the patient's dignity and physical wellbeing
- set out the roles and responsibilities of staff, and
- set requirements for recording, monitoring and reviewing the use of seclusion and any follow-up action.

26.55 In order to ensure that seclusion measures have a minimal impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient's circumstances. Where seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors, facilitating brief periods of access to secure outside areas or allowing meals to be taken in general areas of the ward. The possibility of facilitating such flexibility should be considered during any review of the ongoing need for seclusion. Particularly with prolonged seclusion, it can be difficult to judge when the need for seclusion has ended. This flexibility can provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without terminating the seclusion episode.

Procedure for seclusion

26.56 The following procedure should be incorporated into the provider's policy on seclusion.

Authorising seclusion

Seclusion may be authorised by either:

- A psychiatrist
Additional considerations: if the psychiatrist who authorises seclusion is not the patient's RMO nor a consultant psychiatrist, the on-call consultant psychiatrist should be informed of seclusion as soon as practicable.
- The professional in charge (e.g. a nurse) of a ward
In this case the patient's RMO or on-call consultant psychiatrist must be informed of seclusion as soon as practicable

Commencing seclusion

26.57 Staff may decide what a patient can take into the seclusion area. The patient should never be deprived of clothing when in seclusion.

26.58 The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion.

26.59 When a patient is placed in seclusion, the start time of the seclusion should be recorded in the seclusion record.

26.60 If seclusion was authorised by a psychiatrist who is not a consultant psychiatrist, or by the professional in charge of the ward, the patient's RMO or on-call psychiatrist if the RMO is not available, should attend to undertake the first medical review within one hour of the beginning of seclusion. If the patient is newly admitted, not well known to the staff, or there has been a significant change in the patient's physical, mental state and/or behavioural presentation, this medical review should take place without delay.

Where seclusion has been authorised by a consultant psychiatrist, whether or not they are the patient's RMO, the first medical review will be the review that they undertook immediately before authorising seclusion (meaning that a medical review within one hour of seclusion is not necessary).

- 26.61** Where it has been agreed in a positive behaviour support plan (or equivalent) that family members will be notified of significant behavioural disturbances and the use of restrictive interventions, this should take place as agreed in the plan.

Observation during seclusion

- 26.62** A suitably skilled professional should as a minimum be readily available within sight and sound of the seclusion area at all times throughout the patient's period of seclusion.
- 26.63** The professional should have the means to summon urgent assistance from other staff at any point.
- 26.64** Consideration should be given to whether a male or female person should carry out ongoing observations; this may be informed by consideration of a patient's trauma history.
- 26.65** The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end.
- 26.66** For patients who have received sedation, a skilled professional will need to be outside the door at all times.
- 26.67** A record of the patient's behaviour should be made at least every 15 minutes.
- 26.68** The record made should include, where applicable: the patient's appearance, what they are doing and saying, their mood, their level of awareness and any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis.
- 26.69** Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

Seclusion reviews

- 26.70** A series of review processes should be instigated when a patient is secluded.

These include the multi-disciplinary team (MDT), nursing, medical and independent MDT reviews. All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient's mental and physical state. Where agreed, family members should be advised of the outcomes of reviews.

Medical reviews

26.71 For the purposes of medical reviews, where the RMO is not immediately available, e.g. outside of normal working hours, local policies should make provision for an 'on-call doctor' to deputise for the RMO. The policy should also identify which of their doctors are competent to carry out a medical review.

26.72 The first medical review should:

- if seclusion was authorised either by a psychiatrist who is not a consultant psychiatrist or by the professional in charge of the ward, be undertaken by the RMO or on-call consultant psychiatrist within one hour of the commencement of seclusion, or
- if seclusion was authorised by a consultant psychiatrist (whether or not they are the patient's RMO), be the review that they undertook immediately before seclusion was authorised.

26.73 If it is agreed that seclusion needs to continue, a seclusion care plan should be agreed and prepared, which should identify how the patient's presenting and ongoing needs whilst in seclusion can continue to be met.

26.74 Subsequent medical reviews should be undertaken by either the RMO, a doctor who is an approved clinician, or an on-call doctor.

26.75 Continuing four-hourly medical reviews of secluded patients should be carried out until the first (internal) MDT has taken place including in the evenings, night time, on weekends and bank holidays. A provider's policy may allow different review arrangements to be applied when patients in seclusion are asleep.

26.76 Following the first internal MDT review, further medical reviews should continue at least twice in every 24-hour period. At least one of these should be carried out by the patient's RMO (local arrangements for out-of-hours cover may provide for an alternative approved clinician to cover these RMO reviews).

26.77 Medical reviews provide the opportunity to evaluate and amend seclusion care plans, as appropriate. They should be carried out in person and should include, where appropriate:

- a review of the patient's physical and psychiatric health
- an assessment of adverse effects of medication
- a review of the observations required
- a reassessment of medication prescribed
- an assessment of the risk posed by the patient to others

- an assessment of any risk to the patient from deliberate or accidental self-harm, and
- an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.

Nursing reviews

- 26.78** Nursing reviews of the secluded patient should take place at least every two hours following the commencement of seclusion. These should be undertaken by two individuals who are registered nurses, and at least one of whom should not have been involved directly in the decision to seclude.
- 26.79** In the event of concerns regarding the patient's condition, this should be immediately brought to the attention of the patient's RMO or on-call doctor.
- 26.80** When patients in seclusion are asleep, provider policies may allow reviews to be undertaken in accordance with a revised schedule which should be recorded in the seclusion care plan in order to avoid waking the patient.

MDT reviews

- 26.81** The first internal MDT seclusion review should be held as soon as is practicable.
- 26.82** Appropriate membership of the MDT review meetings should be determined by provider policies. Membership would likely include the RMO, a doctor who is an approved clinician, or an approved clinician who is not a doctor but who has appropriate expertise, the senior nurse on the ward, and staff from other disciplines who would normally be involved in patient reviews.
- 26.83** At weekends and overnight, membership of the initial MDT review may be limited to medical and nursing staff, in which case the on-call senior site manager (or equivalent) should also be involved. Further MDT reviews should take place once in every 24-hour period of continuous seclusion.
- 26.84** Where seclusion continues, these reviews should evaluate and make amendments, as appropriate, to the seclusion care plan.

Independent MDT review

- 26.85** An independent MDT review should be promptly undertaken where a patient has been secluded.

- 26.86** Appropriate membership of the meeting should be determined by provider policies, but as a minimum they should include a doctor who is an approved clinician, or an approved clinician who is not a doctor a nurse and other professionals who were not involved in the incident which led to the seclusion and an IMHA (in cases where the patient has one). It is good practice for the independent MDT to consult those involved in the original decision.
- 26.87** If it is agreed that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan.

Ending seclusion

- 26.88** Seclusion should immediately end when a MDT review, a medical review or the independent MDT review determines it is no longer warranted. Alternatively where the professional in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the patient's RMO or on-call doctor. This consultation may take place in person or by telephone.
- 26.89** Seclusion ends when a patient is allowed free and unrestricted access to the normal ward environment.

Further guidance on seclusion

- 26.90** A seclusion care plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan should include:

- a statement of clinical needs (including any physical or mental health problems), risks and treatment objectives
- a plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed
- details of bedding and clothing to be provided
- details as to how the patient's dietary needs are to be provided for, and
- details of any family or carer contact/communication which will be maintained during the period of seclusion

- 26.91** Wherever possible, the patient should be supported to contribute to the seclusion care plan and steps should be taken to ensure that the patient is aware of what they need to do for the seclusion to come to an end. In view of the potentially traumatising effect of seclusion, care plans should provide details of the support that will be provided when the seclusion comes to an end.

26.92 The seclusion record format should be determined by providers' policies on seclusion. Different providers may use different systems, which may be electronic or paper-based (or a combination of both); in any case they should meet recognised professional record keeping standards. The seclusion record should provide the following details:

- who authorised the seclusion
- the date and time of commencement of seclusion
- the reason(s) for seclusion
- what the patient took into the seclusion room
- if and when a family member, carer and/or advocate was informed of the use of seclusion
- 15 minute recordings by the person undertaking continuous direct observation
- details of who undertook scheduled nursing reviews, their assessment, and a record of the patient's condition and recommendations
- details of who undertook scheduled medical reviews, their assessment and a record of the patient's condition and recommendations
- details of who undertook the independent MDT review, their assessment and a record of the patient's condition and recommendations
- details of who undertook the scheduled MDT reviews, their assessment and a record of the patient's condition and recommendations
- the date and time seclusion ended, and
- details of who determined that seclusion should come to an end

Long-term seclusion

26.93 Long-term seclusion refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement is that, if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time. Where consideration is being given to long-term seclusion, wherever appropriate, the views of the person's family and carers should be elicited and taken into account. The multi-disciplinary review should include an IMHA in cases where a patient has one.

- 26.94** Whilst it is permissible that contact with the general ward population is limited in such circumstances, the environment itself should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow. Facilities which are used to accommodate patients in conditions of long-term seclusion should be configured to allow the patient to access a number of areas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area. Patients should also be able to access secure outdoor areas and a range of activities of interest and relevance to the person.
- 26.95** Patients should not be isolated from contact with staff (indeed it is highly likely they should be supported through enhanced observation), or deprived of access to therapeutic interventions. Treatment plans should aim to end long-term seclusion.
- 26.96** Staff supporting patients who are long-term secluded should make written records on their condition on at least an hourly basis.
- 26.97** The patient's situation should be formally reviewed by an approved clinician who may or not be a doctor at least once in any 24-hour period and at least weekly by the full MDT. The composition of the MDT should be decided by the provider's policy on long-term seclusion, but should include the patient's RMO and an IMHA where appropriate. Provider's policies should provide for periodic reviews by a senior professional who is not involved with the case. The outcome of all reviews and the reasons for continued seclusion should be recorded and the responsible commissioning authority should be informed of the outcome).
- 26.98** The patient's treatment plan should clearly state the reasons why long-term seclusion is required. In these cases, the way that the patient's situation is reviewed needs to reflect the specific nature of their management plan. The purpose of a review is to determine whether the ongoing risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their general health and welfare. The decision to end long-term seclusion should be taken by the MDT (including consultation with the patient's IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient's presentation during close monitoring of the patient in the company of others.
- 26.99** The patient's care plan should outline how they are to be made aware of what is required of them so that the period of long-term seclusion can be brought to an end.

- 26.100** Where successive MDT reviews determine that seclusion continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner.
- 26.101** At times of acute behavioural disturbance where there is a need to contain an immediate risk of harm to others, there may be a need to transfer the person, for a short period of time, to a physical area that is more secure and restrictive and which has been designed for the purpose of seclusion. In such a situation, the procedure for seclusion in the Code should be followed with regards to authorising and commencing seclusion, observation, seclusion reviews and ending seclusion.

Significant restriction on access to normal daytime clothing

- 26.102** Individuals should never be deprived of appropriate clothing with the intention of restricting their freedom of movement, neither should they be deprived of other aids necessary for their daily living.
- 26.103** It may be appropriate, in a small number of instances, for individuals to be asked to wear special tear-proof clothing, such a decision should be authorised by the patient's RMO. This is particularly likely to be the case where the risk of shredded clothing being used to self-harm or attempt suicide has been assessed and is considered to be very high.
- 26.104** Tear-proof clothing should never be a first-line response to such risks and should never be used as a substitute for enhanced levels of support and observation. The requirement to wear tear-proof clothing should never be a blanket rule within a service.
- 26.105** Any tear-proof clothing should fit the person so as to preserve their dignity. It should not be demeaning or stigmatising, and should, where possible, meet any specific cultural or religious requirements.
- 26.106** Any requirement that an individual should wear tear-proof clothing should be proportionate to the assessed risk and documented evidence should show that it is used only as long as absolutely necessary. As soon as the risk is assessed to have diminished, consideration should be given by nursing staff or the MDT team to a return to usual clothing. This will require ongoing dynamic risk assessment.
- 26.107** Positive behaviour support plans (or equivalents) should detail primary preventative strategies that will aim to avoid the ongoing need for such restrictions. The patients should be told what they need to do so that they can wear their usual and preferred clothing.

Following acute behavioural disturbance

- 26.108** Following any episode of acute behavioural disturbance that has led to the use of a restrictive intervention, a post-incident review or debrief should be undertaken so that involved parties, including patients, have appropriate support and there is opportunity for organisational learning. It is important that patients are helped to understand what has happened and why. Patients with limited verbal communication skills may need support to participate in the post incident review or de-briefing.
- 26.109** Where a patient is not able to participate in debriefing, methods for assessing the effects of any intervention on their behaviour, emotions and clinical presentation should be fully explored as part of their assessment(s) and recorded in their positive behaviour support plan (or equivalent).
- 26.110** If the patient is able and agrees to discuss the incident which led to the use of a restrictive intervention, their understanding and experience of the incident should be explored. The patient should be given a choice as to who they would like to discuss their experience with, wherever possible. Attempts by staff to simply justify decisions to use a restrictive intervention may be counterproductive; the aim is to use empathic therapeutic relationships to explore what aspects of the intervention helped, didn't help and might be done differently in future.
- 26.111** Patients' accounts of the incident and their feelings, anxieties or concerns following the restrictive intervention should be recorded in their notes. Positive behaviour support plans (or equivalent) should be reviewed and updated as necessary. Patients should be reminded that they can record their future wishes and feelings about which restrictive interventions (or any other aspect of treatment and care that has been raised by the incident) they would or would not like to be used in an Advance Statement.
- 26.112** If patients wish to formally raise a concern they should be reminded of how to access the local complaints system and independent advocacy services. Patients should also be made aware of how and where to find an accessible version of the hospital policy on restrictive interventions. The hospital's safeguarding lead should be informed whenever a patient raises concerns about restrictive interventions. Patients who need alternative support (e.g. alternative format, additional explanation) should be offered this support to access and use the complaints procedure.
- 26.113** There should be arrangements to support patients (and others) who have suffered serious assaults in hospital including, where appropriate, the involvement of the police.

Patients subject to Guardianship

- 26.114** As is the case for hospital patients, a positive behavioural support planning (or equivalent) framework should be used in relation to those patients subject to Guardianship or on leave of absence who present with behavioural disturbance. Positive behaviour support plans (or equivalents) should be developed as part of the patient's care plan. Seclusion and long-term seclusion should not be used for patients subject to Guardianship or patients who are on leave of absence. The sole exception to this is patients who are on leave of absence to another hospital.
- 26.115** Guardianship does not give anyone the right to treat the patient without their consent to the treatment, if they have capacity to consent to or refuse that treatment. Restrictive interventions that give rise to significant restrictions on liberty go beyond what can be authorised by the conditions of Guardianship. If there are indications that the use of any such restrictive interventions may become necessary, this should prompt consideration as to whether the Guardianship patient should be detained under the Law or whether a significant restriction on liberty authorisation can be sought under the Capacity Law.

Training

- 26.116** All hospitals should have a policy on workforce development and training for staff who may be exposed to aggression or violence in their work or who may need to become involved in the application of restrictive interventions. The policy should specify who will receive what level of training (based on training needs analysis) and how often they will be trained. The policy should require training to be delivered during the induction period of new staff members or as soon as is practicably possible.
- 26.117** All staff who support people who are liable to present with behavioural disturbance should be competent in physical monitoring and emergency resuscitation techniques to ensure the safety of patients following administration of rapid tranquillisation and during periods of physical restraint or seclusion.
- 26.118** All clinical staff who undertake training in the recognition, prevention and management of violence and aggression and associated physical restraint should attend periodic refresher or update education and training programmes.

Security assessments

- 26.119** To manage levels of risk appropriately, the therapeutic environment should be managed carefully through the delivery of a range of security measures. Physical security includes the doors, locks and personal alarms that keep people safe. Procedural security refers to the policies and procedures in place to maintain safety and security. Relational security is the knowledge and understanding that staff have of a patient and of the environment, and the translation of that information into appropriate responses and care. The balance between these three dynamics often shifts, requiring services to change the way in which they meet the needs of a particular patient group or situation. It is essential that all three are in place at all times.
- 26.120** Assessments should consider the level of security (physical, procedural and relational) required to mitigate risks. The application of security measures should aim to promote a safe and therapeutic environment, whilst pro-actively encouraging independence, responsibility and recovery. The use of security should therefore be based on the risk needs of the individual, be as least restrictive as possible, and imposed only when risks have been identified.
- 26.121** Environmental risk assessments of in-patient units must be undertaken annually by an external agency in line with the internal policy.

Section 6: Leaving hospital

Why read this section?

This group of chapters provides guidance in respect of the use of Guardianship and leave of absence from an approved establishment. The use of indefinite leave of absence is a means of enabling patients to leave an approved establishment and to receive treatment in the community. Guidance is provided around its use. Additional guidance is provided in respect of the return of patients to an approved establishment in the event that they are absent without leave.



Chapter 27: Guardianship

Chapter 27

Purpose of Guardianship.....	237
Assessment for Guardianship.....	238
Responsibilities of the Department.....	239
Components of effective Guardianship.....	240
Power to require a patient to live in a particular place	241
Guardianship and hospital care.....	241
Patients who resist the authority of the guardian.....	242
Guardianship orders under Article 66.....	242

Chapter 27: Guardianship

27.1 This Chapter provides guidance on Guardianship, in particular, on the purpose of Guardianship, assessing a patient for Guardianship, the responsibilities of the Minister and the components of effective Guardianship.

Purpose of Guardianship

27.2 The purpose of Guardianship is to enable patients to receive care outside hospital where it cannot be provided without the use of compulsory powers. Such care may, or may not, include specialist medical treatment for mental disorder.

27.3 A guardian may be the Minister or someone else approved by the Minister (a 'private guardian'). Guardians have three specific powers as follows:

- they have the ultimate authority in respect of deciding where a patient should live,
- they can require the patient to attend for treatment, work, training or education at specific times and places (but they cannot use force to take the patient there), and
- they can require and facilitate the access of a doctor, AO or another person relevant to the patient at the place where the patient lives.

27.4 Guardianship therefore provides an authoritative framework for working with a patient, with a minimum of constraint, to achieve as independent a life as possible within the community. Where it is used, it should be part of the patient's overall care plan.

27.5 Guardianship must not be used to impose restrictions that amount to a Significant Restriction on Liberty (as defined in Part 5 of the Capacity Law).

27.6 Guardianship does not give anyone the right to treat the patient without their permission or to consent to treatment on their behalf.

27.7 While the reception of a patient into Guardianship does not affect the continued authority of an attorney or delegate appointed under the Capacity Law, such attorneys and delegates will not be able to make decisions about where a Guardianship patient is to reside, or make any other decisions which conflict with decisions made by the guardian.

Assessment for Guardianship

27.8 An application for Guardianship may be made, in relation to a patient on the grounds that:

- the patient is suffering from mental disorder of a nature or degree which warrants their reception into Guardianship, and
- it is necessary, in the interests of the welfare of the patient or for the protection of other persons, that the patient should be so received

27.9 Guardianship is most likely to be appropriate where:

- the patient is thought to be likely to respond well to the authority and attention of a guardian and so be more willing to accept the proposed care and treatment for their mental disorder, and
- there is a particular need for someone to have the authority to decide where the patient should live or to require that doctors, AOs or other people be given access to the patient.

27.10 As with applications for detention in hospital (see Chapter 12), AOs and doctors making recommendations should consider whether the objectives of the proposed application could be achieved in another, less restrictive way, without the use of Guardianship.

27.11 Where patients lack capacity to make some or all important decisions concerning their own welfare, one potential alternative to Guardianship will be to rely solely on the Capacity Law – especially the protection from liability for actions taken in connection with care or treatment provided by Part 5 of the Capacity Law. While this is a factor to be taken into account, it will not by itself determine whether Guardianship is necessary or unnecessary. AOs and doctors need to consider all the circumstances of the particular case.

27.12 Where a patient is assessed as requiring residential care but lacks the capacity to make a decision about whether they wish to be placed there, Guardianship is unlikely to be necessary where the move can properly, quickly and efficiently be carried out on the basis of Part 5 of the Capacity Law or the decision of an attorney or delegate.

27.13 Guardianship may still be appropriate in such cases if:

- there are other reasons – unconnected to the move to residential care – to believe that the patient might benefit from the attention and authority of a guardian;
- there is a particular need to have explicit statutory authority for the patient to be returned to the place where the patient is to live should they go absent, or

- it is thought to be important that decisions about where the patient is to live are placed in the hands of a single person or authority – e.g. where there have been long-running or particularly difficult disputes about where the person should live.

27.14 It will not always be best to use Guardianship as the way of deciding where patients who lack capacity to decide for themselves must live. In cases which raise unusual issues, or where Guardianship is being considered in the interests of the patient's welfare and there are finely balanced arguments about where the patient should live, it may be preferable instead to seek a best interests decision from the court according to Part 5 of the Capacity Law.

27.15 Where the relevant criteria are met, Guardianship may be considered in respect of a patient who is to be discharged from detention under the Law. However, if it is thought that the patient needs to remain liable to be recalled to hospital (and the patient is eligible), use of indefinite leave of absence (see Chapter 29) may be preferable.

Responsibilities of the Department

27.16 The Department should establish a protocol setting out the arrangements for receiving, scrutinising and accepting or refusing applications for Guardianship.

Such arrangements should ensure that applications are properly but quickly dealt with.

The Department also has responsibilities for:

- monitoring the progress of each patient's Guardianship, including steps to be taken to fulfil the authority's statutory obligations in relation to private guardians and to arrange visits to the patient
- ensuring the suitability of any proposed private guardian, and that they are able to understand and carry out their duties under the Law
- ensuring that patients under Guardianship receive, both orally and in writing, information in accordance with regulations under the Law, including their right to have access to an Independent Mental Health Advocate (IMHA)
- ensuring that patients are aware of their right to apply to a Tribunal and that patients are given the name of someone who will give them necessary assistance, on behalf of the Minister, in making such an application;
- maintaining detailed records relating to Guardianship patients;

- ensuring that the need to continue Guardianship is reviewed in the last two months of each period of Guardianship in accordance with the Law, and
- discharging patients from Guardianship as soon as it is no longer required.

27.17 Patients may be discharged from Guardianship at any time by the Minister or the RMO authorised by the Minister. An application for discharge may also be made by either the patient or their Nearest Person.

Components of effective Guardianship

27.18 An application for Guardianship should be accompanied by a comprehensive care plan established on the basis of multi-disciplinary discussions.

27.19 The plan should identify the services needed by the patient and who will provide them. It should also indicate which of the powers that guardians have under the Law are necessary to achieve the plan.

27.20 Key elements of the plan are likely to be:

- suitable accommodation to help meet the patient's needs
- access to suitable daytime activity, education and training facilities, as appropriate
- effective co-operation and communication between all persons concerned in implementing the care plan
- (if there is to be a private guardian) support from the Department for the guardian.

27.21 A private guardian or the Minister should be prepared to advocate on behalf of the patient in relation to those agencies whose services are needed to carry out the care plan.

27.22 A private guardian should be a person who can appreciate any special disabilities and needs of a mentally disordered person and who will support the patient in an appropriate, compassionate and responsive way. The guardian should have a thorough understanding of the least restrictive principle. The guardian should display an interest in promoting the patient's physical and mental health and in providing for their occupation, training, employment, recreation and general welfare in a suitable way. The Minister must satisfy himself that a proposed private guardian is capable of carrying out their functions.

Power to require a patient to live in a particular place

- 27.23** Guardians have the power to decide where patients should live. If patients leave the place they are required to live without the guardian's permission, they can be taken into legal custody and brought back to the specified premises.
- 27.24** This power can also be used to take patients for the first time to the place they are required to live, if patients do not (or, in practice, cannot), go there by themselves.
- 27.25** Patients should always be consulted first about where they are to be required to live, unless their mental state makes that impossible. Guardians should not use this power to make a patient move without warning.
- 27.26** The power to take or return patients to the place they are required to live may be used, e.g. to discourage them from:

- living somewhere the guardian considers unsuitable
- breaking off contact with services
- leaving the area before proper arrangements can be made, and
- sleeping rough.

However, it may not be used to restrict their freedom to come and go so much that they are effectively being detained. In the event that additional powers are required in order to facilitate such a restriction, consideration should be given to using the Capacity Law.

- 27.27** The power to require patients to reside in a particular place may not be used to require them to live in a situation in which their liberty is significantly restricted. In such instances consideration should be given to using the Capacity Law.
- 27.28** It is not necessary to apply for a further Guardianship order in the event that the patient's place of residence changes provided that the Guardian remains the same.
- 27.29** A new application for a Guardianship order is required in the event that the Guardian changes.

Guardianship and hospital care

- 27.30** Guardianship does not restrict patients' access to hospital services on an informal basis. Patients who require treatment but do not need to be detained may be admitted informally in the same way as any other patient. This applies both to physical and mental healthcare.

27.31 Nor does Guardianship prevent a significant restriction on liberty being authorised under the Capacity Law in the event that the person needs to be detained in a hospital in their best interests in order to receive care and treatment. Authorisation for a significant restriction on liberty or court order can be sought so long as:

- it would not be inconsistent with the guardian’s decision about where the patient should live, and
- the person does not object to being kept in hospital for treatment for mental disorder or to receiving that treatment

27.32 Otherwise, Guardianship should not be used to require a patient to reside in a hospital except where it is necessary for a very short time in order to arrange alternative accommodation in the community.

27.33 Guardianship can remain in force if the patient is detained in hospital under Article 21 of the Law for assessment (or under the holding powers associated with Article 15 and 17), but it ends automatically if a patient is detained for treatment as a result of an application under Article 22. A patient may be transferred from Guardianship to detention in hospital under Article 22. The normal requirements for an application and medical recommendations must be met, and the transfer must be agreed by the Minister.

Patients who resist the authority of the guardian

27.34 If a patient consistently resists the requirements of a Guardianship order, it can normally be concluded that Guardianship is not the most appropriate form of care for that person, and the Guardianship should be discharged. The Minister should first consider whether a change of guardian – or change in the person who, in practice, exercises the Minister’s powers as guardian – might be appropriate instead.

Guardianship orders under Article 66

27.35 Guardianship may be used by courts as an alternative to hospital orders for offenders with mental disorders where the criteria set out in the Law are met. The court must first be satisfied that the Minister or named person is willing to act as guardian. In considering the appropriateness of the patient being received into their Guardianship the same considerations as apply to applications for Guardianship under Part 4 of the Law apply.



Chapter 28: Leave of absence

Chapter 28

General points	244
Power to grant leave	244
Restricted patients.....	245
Short-term leave	245
Longer periods of leave.....	245
Indefinite Leave.....	246
Recording leave.....	247
Care and treatment while on leave	247
Leave to reside in other Approved Establishments.....	247
Revocation and variation of leave of absence	248
Renewal of authority to detain.....	248
Patients who are in an Approved Establishment but not detained.....	248

Chapter 28: Leave of absence

28.1 This Chapter provides guidance on leave of absence for detained patients under Article 24 of the Law.

General points

28.2 In general, a patient subject to an assessment or treatment authorisation may be given leave of absence by their RMO under Article 24 of the Law.

28.3 An RMO cannot grant leave of absence from an Approved Establishment to patients who have been remanded to an Approved Establishment under Articles 62 or 63 of the Law or who are subject to interim hospital orders under Article 64.

28.4 Any area outside of the walls of the Approved Establishment is to be regarded as requiring Article 24 Leave in respect of patients who are formally detained.

Power to grant leave

28.5 Only the patient's RMO can grant leave of absence to a patient detained under the Law. They cannot delegate the decision to grant leave of absence to anyone else. In the absence of the usual RMO (e.g. if they are on leave), permission can only be granted by the AP who is for the time being acting as the patient's RMO, or if out of hours the on call AP.

28.6 RMOs can grant leave for specific occasions or for specific periods of time. There is no restriction on the period of time for which leave of absence can be granted. They may make leave subject to any conditions which they consider necessary in the interests of the patient or for the protection of other people.

28.7 The Department cannot overrule an RMO's decision to grant leave. However, the fact that a RMO grants leave subject to certain conditions, e.g. residence at a particular place, does not oblige the Department or anyone else to arrange or fund the particular placement or services that the medical officer has in mind. RMOs should not grant leave on such a basis without first taking steps to establish that the necessary services or accommodation (or both) are available.

Restricted patients

- 28.8** Any proposal to grant leave to a restricted patient has to be approved by the court, who should be given as much notice as possible and full details of the proposed leave.
- 28.9** Where the court has decided that restricted patients are to be detained in a particular unit of an Approved Establishment, those patients require leave of absence to go to any other part of that Approved Establishment as well as outside the Approved Establishment. The court would normally consider any request for Article 24 Leave for a restricted patient to be in the community for more than a few consecutive nights as an application for conditional discharge.

Short-term leave

- 28.10** Subject to the agreement of the court in the case of restricted patients, RMOs may decide to authorise short-term local leave, which may be managed by other staff. For example, patients may be given leave for a shopping trip of two hours every week to a specific destination, with the decision on which two hours to be left to the discretion of the responsible nursing staff.
- 28.11** The parameters within which this discretion may be exercised must be clearly set out by the RMO, e.g. the particular places to be visited, any restrictions on the time of day the leave can take place and any circumstances in which the leave should not go ahead.
- 28.12** RMOs should regularly review any short-term leave they authorise on this basis and amend it as necessary.

Longer periods of leave

- 28.13** Longer-term (extended), leave should be planned properly and, where possible, well in advance. Patients should be fully involved in the decision and RMOs should be satisfied that patients are likely to be able to manage outside the Approved Establishment. Subject to the normal considerations of patient confidentiality, carers and other relevant people should be consulted before leave is granted (especially where the patient is to reside with them). Relevant community services should also be consulted.
- 28.14** If patients do not consent to carers or other people who would normally be involved in their care being consulted about their leave, RMOs should reconsider whether or not it is safe and appropriate to grant leave.

Indefinite Leave

- 28.15** A patient may be discharged from hospital but remain subject to detention according to Article 22 on the basis that they continue to meet the criteria for detention and continue to be in need of treatment for a mental disorder. As Article 22 can be renewed, this can result in Article 24 Leave being for an indefinite period.
- 28.16** A patient who is granted indefinite leave has the same status and rights as a patient who is detained in hospital according to Article 22. In particular, the patient will have the same right to apply to a Mental Health Review Tribunal for discharge. The patient's Nearest Person also retains the same right to apply to a Mental Health Review Tribunal for the patient's discharge.
- 28.17** Indefinite leave may only last for as long as the duration of the detention according to Article 22. In effect this means that a patient may only be granted leave for a period of up to 6 months. However, as the Article 22 may be renewed for a further period of 6 months followed by further periods of 12 months, the duration of indefinite leave can mirror these periods of renewed detention.
- 28.18** Indefinite leave ends immediately once a patient is discharged from Article 22.
- 28.19** Indefinite leave cannot be granted to patients who are detained according to Article 21 as this Article cannot be renewed. A patient may however be granted leave if detained according to Article 21 but in practice this could last no longer than a period of 28 days.
- 28.20** A patient must comply with a course of medical treatment during the period that they are granted indefinite leave. The definition of treatment is broad and further details are provided in Article 1 of the Law.
- 28.21** A SOAD would be required to review any treatments within the scope of Part 6 before liability to continued detention could be renewed.
- 28.22** Indefinite leave cannot be renewed until such time as a patient's liability to continued detention is renewed. There is no requirement for a further Mental Health Law assessment in order to renew a treatment authorisation (and the indefinite leave which may be attached to the order). However, the RMO may request a new Mental Health Law assessment if he concludes that this would benefit the patient.

Recording leave

- 28.23** The Department should establish a standardised system by which RMOs can record the leave they authorise and specify the conditions attached to it. Copies of the authorisation should be given to the patient and to their Nearest Person and carers. It is expected that other people will be notified as required. A copy should also be kept in their notes. In case they fail to return from leave, an up-to-date description of the patient should be available in their notes.
- 28.24** The outcome of leave – whether or not it went well, particular problems encountered, concerns raised or benefits achieved – should also be recorded in patients’ notes to inform future decision making. Patients should be encouraged to contribute by giving their own views on their leave.

Care and treatment while on leave

- 28.25** RMOs’ responsibilities for their patients remain the same while the patients are on leave.
- 28.26** A patient who is granted leave under Article 24 remains liable to be detained, and the rules in Part 6 of the Law about their medical treatment continue to apply. If it becomes necessary to administer treatment without the patient’s consent, consideration should be given to whether it would be more appropriate to recall the patient to an Approved Establishment although recall is not a legal requirement.

Leave to reside in other Approved Establishments

- 28.27** RMOs may also require patients, as a condition of leave, to reside at another Approved Establishment within Jersey, and they may then be kept in the care of staff of that Approved Establishment. However, before authorising leave on this basis, RMOs should consider whether it would be more appropriate to transfer the patient to the other Approved Establishment instead.
- 28.28** Where a patient is granted leave of absence to another Approved Establishment, the RMO at the first Approved Establishment should remain in overall charge of the patient’s case.

Revocation and variation of leave of absence

- 28.29** The RMO may revoke their patient's leave, or vary the terms and conditions, at any time if they consider it necessary.
- 28.30** The RMO must arrange for a notice in writing revoking the leave to be provided to the patient or on the person who is for the time being in charge of the patient. Approved Establishments should always know the address of patients who are on leave of absence.
- 28.31** The reasons for recall should be fully explained to the patient and a record of the explanation included in the patient's notes. A restricted patient's leave may be revoked either by the RMO or by the court.
- 28.32** In the event that a patient needs to be recalled to hospital out of hours or at any time when their RMO is unavailable, the function to recall may be delegated to any other consultant psychiatrist who must then communicate to the patient's RMO the reason for recall.
- 28.33** A written notice of recall must be provided to the patient or the person in charge of the patient unless the patient is able and willing to provide valid consent to return to hospital of their own volition. This option should be offered to a patient who would otherwise be subject to recall to hospital as a less restrictive outcome.

Renewal of authority to detain

- 28.34** It is possible to renew a patient's detention while they are on leave if the criteria in Article 24 of the Law are met. However leave should not be used as an alternative to discharging the patient either completely.

Patients who are in an Approved Establishment but not detained

- 28.35** Patients who are not legally detained in an Approved Establishment have the right to leave at any time. They cannot be required to ask permission to do so but will be asked to inform staff when they wish to leave the ward due to the need to ensure that the general security on the ward is maintained. It may be advisable that an informal patient receives support from staff when having leave from the ward (escorted or accompanied leave). However, an informal patient cannot be compelled to accept such support and has the right to refuse it.



Chapter 29: Absence without leave

Chapter 29

General points	250
Detained patients	250
Guardianship patients.....	251
Other situations in which patients are in legal custody.....	251
Policy	251

Chapter 29: Absence without leave

29.1 This Chapter gives guidance about action to be taken when patients are absent without leave (AWOL) or have otherwise absconded from legal custody under the Law.

General points

29.2 Under Article 28 of the Law, patients are considered to be AWOL in various circumstances, in particular when they:

- have left the Approved Establishment in which they are detained without their absence being agreed (under Article 24 of the Law) by their RMO
 - have failed to return to the Approved Establishment at the time required to do so by the conditions of leave under Article 24
 - are absent without permission from a place where they are required to reside as a condition of leave under Article 24
 - have failed to return to an Approved Establishment when their leave under Article 24 has been revoked,
- or
- are conditionally discharged restricted patients whom the Department has recalled to an Approved Establishment.

Detained patients

29.3 Detained patients who are AWOL may be taken into custody and returned by the RMO, any person appointed by the RMO, an AO or a police officer.

29.4 A patient who has been required to reside in another Approved Establishment as a condition of leave of absence can also be taken into custody by any member of that Approved Establishment's staff appointed by the RMO.

29.5 However, patients (other than restricted patients) cannot be taken into custody under Article 37 of the Law:

- after the end of their current period of detention (ignoring any extra time that would be allowed if the patient were to return or be taken into custody right at the end of that period).

29.6 There is no such time limit for restricted patients. They may be retaken for as long as they remain subject to restrictions.

Guardianship patients

29.7 Guardianship patients who are AWOL from the place they are required to live may be taken into custody by any member of the staff of a Department, any person authorised in writing by the Department or the private guardian (if there is one), or a police officer.

Other situations in which patients are in legal custody

29.8 In addition, there are various situations in which patients are considered to be in legal custody under the Law. These include, e.g.:

- the detention of patients in places of safety under Articles 34 or 35
- the transport of patients to hospital (or elsewhere) under the Law, including patients being returned to hospital when they have gone AWOL, and
- where patients' leave of absence is conditional on their being kept in custody by an escort.

29.9 If patients who are in legal custody abscond, they may also be taken into custody and returned to the place they ought to be, in accordance with the Law.

Policy

29.10 The Department should ensure that there is a clear written policy about the action to be taken when a detained patient goes missing. All relevant staff should be familiar with this policy. The Department should agree their policy with other agencies such as the police and ambulance service – as necessary.

29.11 The police should be asked to assist in returning a patient to an Approved Establishment only if necessary. If the patient's location is known, the role of the police should, wherever possible, be only to assist a suitably qualified and experienced mental health professional in returning the patient to an Approved Establishment.

29.12 The police should always be informed immediately if a patient is missing who is:

- considered to be particularly vulnerable;
- considered to be dangerous; or
- subject to restrictions under Part 9 of the Law.

29.13 There may also be other cases where, although the help of the police is not needed, a patient's history makes it desirable to inform the police that they are AWOL.

29.14 Whenever police are asked for help in returning a patient, they must be informed of the time limit for taking them into custody.

29.15 Where the police have been informed about a missing patient, they should be told immediately if the patient is found or returns.

29.16 Although every case must be considered on its merits, patient confidentiality will not usually be a barrier to providing basic information about a patient's absence to people – such as those the patient normally lives with or is likely to contact – who may be able to help with finding the patient.

29.17 Where a patient is missing for more than a few hours, their Nearest Person should normally be informed (if they have not been informed already), subject to the normal considerations about involving Nearest Persons.

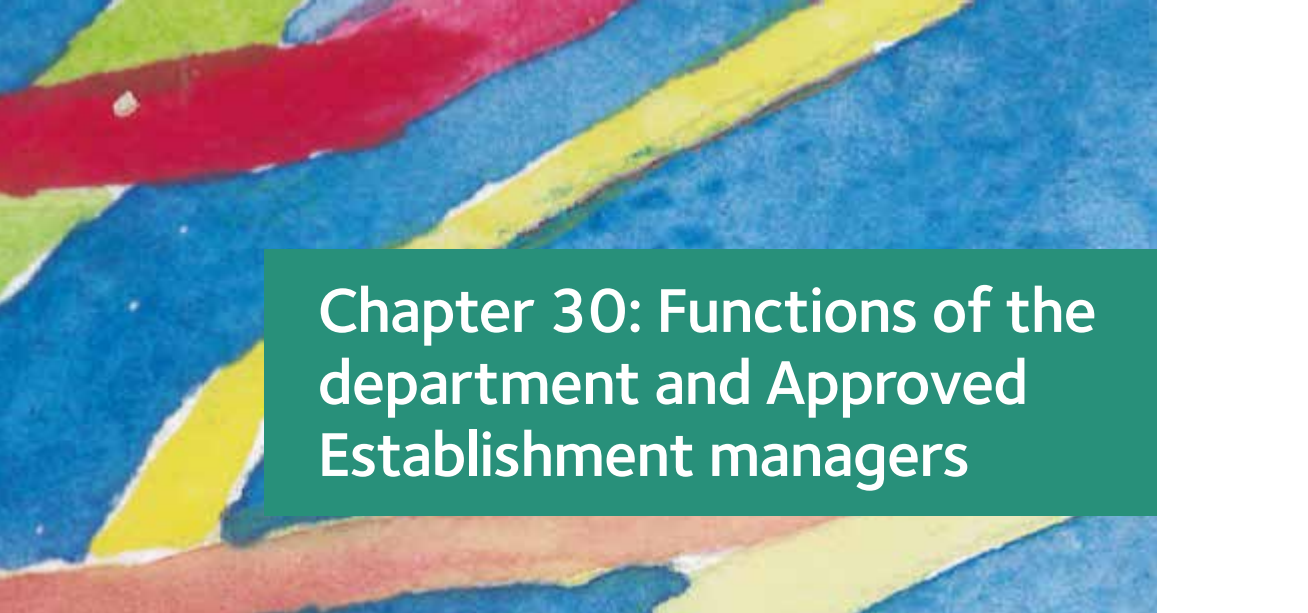
29.18 It is good practice when a detained patient returns after a substantial period of absence without leave to re-examine the patient to establish whether they still meet the criteria for detention.

29.19 All instances of absence without leave should be recorded in the individual patient's notes. Where a patient has gone AWOL previously, it may be useful for the patient's care plan to include specific actions which experience suggests should be taken if that patient were to go missing again.

Section 7: Professional Responsibilities

Why read this section?

Hospital managers and others have specific roles under the Law. Guidance is provided in respect of these. Additionally, this group of chapters provides guidance on responsibilities in relation to the receipt and scrutiny of documents.



Chapter 30: Functions of the department and Approved Establishment managers

Chapter 30

Identification of Approved Establishment managers.....	256
Exercise of Approved Establishment managers' functions	256
Specific powers and duties of Approved Establishment managers	257

Chapter 30: Functions of the department and Approved Establishment managers

30.1 This Chapter gives general guidance on the responsibilities of the Department and Approved Establishment managers under the Law, and on specific powers and duties not addressed in other Chapters, including those in relation to transfers between Approved Establishments, victims of crime, patients' correspondence and references to the Tribunal.

Identification of Approved Establishment managers

30.2 States' medical establishments are the responsibility of the Department, which acts for these establishments as the Approved Establishment manager. In an independent establishment, the owners are the Approved Establishment managers.

30.3 Approved Establishment managers have the primary responsibility for seeing the requirements of the Law are followed. In particular, they must ensure that patients are detained only as the Law allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights.

30.4 In practice, most of the decisions of the Approved Establishment managers are actually taken by individuals (or groups of individuals) on their behalf.

Exercise of Approved Establishment managers' functions

30.5 Approved Establishment managers may arrange for their functions to be carried out, day to day, by particular people on their behalf.

30.6 Organisations (or individuals) retain responsibility for the performance of all Approved Establishment managers' functions exercised on their behalf and must ensure that the people acting on their behalf are competent to do so. It is for the organisation (or individual) concerned to decide what arrangements to put in place to monitor and review the way that functions under the Law are exercised on its behalf.

Specific powers and duties of Approved Establishment managers

Admissions

- 30.7** It is the responsibility of Approved Establishment managers to ensure that any relevant admission documents are in order.

Transfer between Approved Establishments

- 30.8** The Law allows the Minister to authorise the transfer of most detained patients from one Approved Establishment to another. This role will be delegated to Approved Establishment managers, with the consent of the patient's RMO.
- 30.9** A patient who is subject to a hospital treatment authorisation or a hospital treatment authorisation with restrictions may with the consent of his RMO and the court, be transferred to another Approved Establishment.
- 30.10** Approved Establishment managers should ensure that there are good reasons for the transfer and that the needs and interests of the patient have been considered. Transfers are potentially an interference with a patient's right to respect for privacy and family life under Article 8 of the ECHR, and care should be taken to act compatibly with the Convention when deciding to authorise a transfer.
- 30.11** Valid reasons for transfer might be clinical – the need, for example, for the patient to be in a more suitable environment or in a specialist facility. In some cases, a transfer may be unavoidable, because the Approved Establishment is no longer able to offer the care that the patient needs.
- 30.12** Wherever practicable, patients should be involved in the process leading to any decision to transfer them to another Approved Establishment. It is important to explain the reasons for the proposed transfer to the patient, and where appropriate, their Nearest Person or significant others and to record them. Only in exceptional circumstances should patients be transferred to another Approved Establishment without warning.
- 30.13** Requests made by, on or behalf of a patient for a transfer to another Approved Establishment, should be recorded and given careful consideration. If a transfer cannot take place, the patient (or the person who made the request on the patient's behalf) should be given a written statement of the decision and the reasons for it.
- 30.14** Nearest Persons' consent to transfers is not a statutory requirement. However, unless the patient objects, the patient's Nearest Person should normally be consulted before a patient is transferred to another Approved Establishment, and, in accordance with Article 13(5), they must be notified of the transfer as soon as practicable after the exercise of these powers.

- 30.15** When a patient is transferred, the documents authorising detention, including the authority for transfer, should be sent to the Approved Establishment to which the patient is transferred. The transferring Approved Establishment should retain copies of these documents.

Information for patients and relatives

- 30.16** Articles 13 and 78 of the Law requires Approved Establishment managers to arrange for detained patients and (where relevant) their Nearest Persons to be given important information about the way the Law works and about their rights.

Patient's correspondence

- 30.17** Article 83 allows Approved Establishment managers to withhold outgoing post from detained patients if the person to whom it is addressed has made a written request to the Approved Establishment managers; or if the Approved Establishment managers consider that it is likely to cause distress to the person to whom it is addressed or to any other person; or because they believe it is likely to cause danger to any person. The fact that post has been withheld must be recorded.
- 30.18** Article 83 also allows for Approved Establishment managers to withhold incoming post to patients, if in their opinion, it is necessary to do so in the interest of the safety of the patient or for the protection of other persons. If post has been withheld, it must be recorded and the patient notified, and if known, the person who sent the post. Great care should be taken before post is withheld as there is a real risk of this decision being challenged on human rights grounds.
- 30.19** The Approved Establishment managers should have a written protocol for the exercise of these powers.



Chapter 31: Receipt and scrutiny of documents

Chapter 31

Statutory forms.....	260
Audit.....	262

Chapter 31: Receipt and scrutiny of documents

31.1 This Chapter provides guidance on the receipt and scrutiny of documents under the Law.

Statutory forms

31.2 The Law requires that prescribed forms be used for certain applications, recommendations, orders, reports and records under the Law.

31.3 Electronic forms should be used at all times. In the event that this is not possible then completed paper versions of the electronic forms are permissible. The person completing the form is then responsible for completing the form electronically once access to the electronic system is re-established. The paper based form need only be uploaded if evidence of signatures is required that are not included in any digital signatures, such as an agreement by the patient.

31.4 Orders for detention under the Law should be emailed (or delivered in hard copy if paper versions have been used), to the detaining ward in order for them to be received.

31.5 People who make orders, sign applications and make the supporting medical recommendations must take care to comply with the requirements of the Law. People who act on the authority of these documents should also make sure that they are completed accurately, as an incorrectly completed or indecipherable form may not constitute authority for a patient's detention.

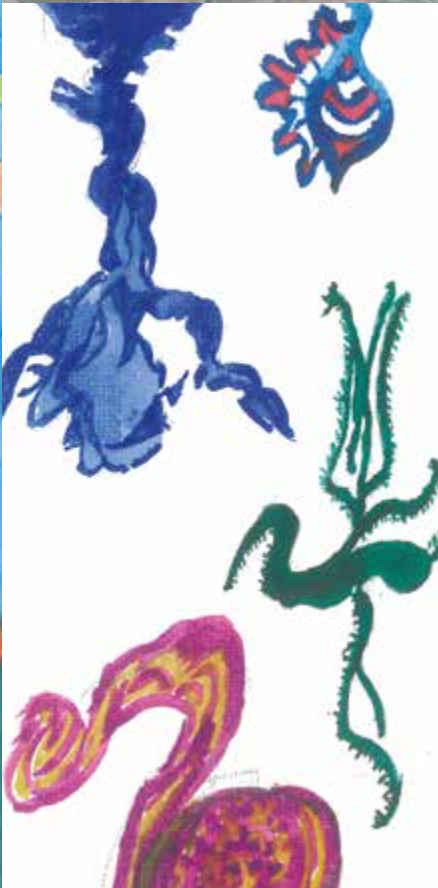
31.6 This Chapter distinguishes between receiving admission documents and scrutinising them. For these purposes, receipt involves receiving documents by electronic means or hard copy and checking that they appear to amount to an order that has been duly granted. Scrutiny involves more detailed checking for omissions, errors and other defects.

- 31.7** Someone with authority to receive admission documents should be available at all times at which patients may be admitted to the Approved Establishment. A manager of appropriate seniority should take overall responsibility on behalf of the Approved Establishment managers for the proper receipt and scrutiny of documents.
- 31.8** Guidelines will be provided to Approved Establishment managers in order to support staff members who receive documents to detect those errors which fundamentally invalidate an order and which cannot be corrected at a later stage in the procedure.
- 31.9** Where the staff member is not authorised by the Approved Establishment managers to agree to the rectification of a defective admission document, the documents must be scrutinised by a person who is authorised to do so. This scrutiny should happen at the same time as the documents are received or as soon as possible afterwards (and certainly no later than the next working day).
- 31.10** Documents should be scrutinised for accuracy and completeness and to check that they do not reveal any failure to comply with the procedural requirements of the Law in respect of applications for detention.
- 31.11** Forms or documents which are found to be incorrect or defective must be rectified as soon as is reasonably practicable which will usually mean immediately after the error or defect was noticed. When rectification has taken place, the prescribed form shall be deemed to have been completed as if it had originally been completed as rectified. Rectification cannot be used to remedy a genuinely deficient form or document, which would otherwise invalidate the application.
- 31.12** The AO has overall responsibility for the assessment process and this includes ensuring that documents are completed accurately. The AO must check all of the relevant documentation and be satisfied in its completion prior to presenting the documents to the Administrator.
- 31.13** Having received the documents, the Administrator is tasked with ensuring that there are no defects which would fundamentally invalidate a detention. In the event that an error is not rectifiable under the Law, the detention thereby becomes invalid. A new Mental Health Law assessment would be required in order to ensure that continued detention remains lawful. Emergency holding powers may be employed in the interim.
- 31.14** In the event that there is one or more defects which would not fundamentally invalidate a detention, the Administrator must request that the author of the defective document rectifies the error or errors at the earliest available opportunity.

Audit

- 31.15** Approved Establishment managers are responsible for ensuring that patients are lawfully detained.
- 31.16** Approved Establishment managers should ensure that staff who are receiving and scrutinising statutory documents on their behalf are competent to perform these duties, understand the requirements of the Law and receive suitable training.
- 31.17** Approved Establishment managers should also ensure that arrangements are in place to audit the effectiveness of receipt and scrutiny of documents on a regular basis.













**This document has been produced by
and on behalf of The States of Jersey.**

First published 2018.

This document contains public sector information
licensed under the Open Government Licence v3.0.

Published by Üs Creatives, 32 Burrard Street,
St Helier, Jersey JE2 4WS www.uscreatives.co.uk