



Jersey

# **MENTAL HEALTH (MISCELLANEOUS PROVISIONS AND PRESCRIBED FORMS) (JERSEY) ORDER 2018**

## **Official Consolidated Version**

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Jersey

## MENTAL HEALTH (MISCELLANEOUS PROVISIONS AND PRESCRIBED FORMS) (JERSEY) ORDER 2018

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Jersey

## MENTAL HEALTH (MISCELLANEOUS PROVISIONS AND PRESCRIBED FORMS) (JERSEY) ORDER 2018

**THE MINISTER FOR HEALTH AND SOCIAL SERVICES**, in pursuance of Articles 6, 10, 15, 16, 17, 18, 24, 27, 29, 38, 45 and 95 of the [Mental Health \(Jersey\) Law 2016](#), orders as follows –

Commencement [[see endnotes](#)]

### 1 Interpretation

In this Order –

“General Medical Council” means the body corporate of that name continued by section 1 of the Medical Act 1983 of the United Kingdom;

“Law” means the [Mental Health \(Jersey\) Law 2016](#);

“Royal College of General Practitioners” means the body corporate of that name established by Royal Charter and registered as a charity under the Charities Act 2011 of the United Kingdom;

“Royal College of Psychiatrists” means the body corporate of that name established by Royal Charter and registered as a charity under the Charities Act 2011 of the United Kingdom.

### 2 Authorized officers: training and experience requirements

- (1) A person authorized as an officer under Article 6(1) of the Law must be a person who –
  - (a) fulfils one of the training requirements in paragraph (2); and
  - (b) has the experience specified in paragraph (3).
- (2) The requirements mentioned in paragraph (1)(a) are that the person –
  - (a) is trained as an Approved Mental Health Professional within the meaning given by the Mental Health Act 1983 of the United Kingdom, and has completed the [Mental Health \(Jersey\) Law 2016](#) Introductory Training Programme;
  - (b) is trained as a Mental Health Officer within the meaning given by the Mental Health (Scotland) Act 2015 of the Scottish Parliament, and has completed the [Mental Health \(Jersey\) Law 2016](#) Introductory Training Programme; or
  - (c) has completed the [Mental Health \(Jersey\) Law 2016](#) Authorized Officer Training Programme.

- (3) The experience mentioned in paragraph (1)(b) is not less than 2 years' experience in such aspects of mental health legislation and practice as the Minister may consider appropriate.
- (4) The training programmes prescribed for the purposes of Article 6 of the Law are the training programmes known by the names mentioned in paragraph (2) and approved by the Minister for those purposes.

### **3 Approved practitioners: evidence of training and experience requirements<sup>1</sup>**

- (1) In order to satisfy the Minister, for the purposes of granting approval under Article 16 of the Law, that a registered medical practitioner has sufficient experience and training in the field of mental health and the operation of legislation relating to mental health, the registered medical practitioner must produce –
  - (a) evidence of holding a full registration with licence to practise from the General Medical Council; and
  - (b) evidence that he or she also fulfils one of the requirements in paragraph (2) or, where paragraph (3) applies, the requirement in paragraph (4).
- (2) The requirements mentioned in paragraph (1)(b) are that the registered medical practitioner –
  - (a) is a member or fellow of the Royal College of Psychiatrists and has attained approval to practise as an approved practitioner following completion of the [Mental Health \(Jersey\) Law 2016](#) Approved Practitioner Training Programme;
  - (b) is a member of the Royal College of General Practitioners appearing on the National Performers List with a minimum of 3 years' full-time experience including –
    - (i) substantial experience in the diagnosis or treatment of mental disorder, and
    - (ii) at least 4 months spent in a supervised psychiatric training post within a training programme recognized by the Royal College of Psychiatrists,and has attained approval to practise as an approved practitioner following completion of the [Mental Health \(Jersey\) Law 2016](#) Approved Practitioner Training Programme; or
  - (c) has –
    - (i) a minimum of 3 years' full-time experience in either a psychiatric training post or a non-consultant career grade post, including in each case substantial experience in the diagnosis or treatment of mental disorder, and
    - (ii) attained approval to practise as an approved practitioner following completion of the [Mental Health \(Jersey\) Law 2016](#) Approved Practitioner Training Programme.
- (3) This paragraph applies where the Minister intends to attach a condition to the approval, under Article 16(2) of the Law, that the registered medical practitioner may exercise the powers under the Law given to approved practitioners only to the extent of being qualified to be appointed as (and therefore having the authority to discharge the functions of) a medical member of the Mental Health Review Tribunal Panel under Article 47 of the Law.



- (4) The requirement mentioned in paragraph (1)(b) is that the registered medical practitioner has such degree of experience or training in mental health matters as would reasonably be expected to provide him or her with enough understanding of the medical issues likely to arise before the Mental Health Review Tribunal to be an effective medical member.

#### **4 SOADs: level of expertise required**

For the purposes of approval for carrying out the functions of a SOAD under Part 6 of the Law, a registered medical practitioner must also be –

- (a) a Member or Fellow of the Royal College of Psychiatrists; and
- (b) registered, on the register of the General Medical Council, as qualified to provide specialist services in the field of mental health.

#### **5 Determination of age of patients**

- (1) This Article applies where –
  - (a) the date of birth of a patient is material for any of the purposes of the Law, the Capacity Law, or any enactment made under those Laws; but
  - (b) the patient's exact age is not known or cannot be ascertained by reference to a Jersey register.
- (2) Where this Article applies –
  - (a) the Minister must determine the patient's age, in accordance with such information in respect of the patient's age which the Minister is able to obtain –
    - (i) by reference to any birth certificate, passport or other document of identity issued in respect of the patient by an authority having power to do so under the laws in force in any country or territory, or
    - (ii) (failing such information, or upon such information being insufficient) by any other reasonable means; and
  - (b) the Minister must issue, to the persons listed in paragraph (4), a certificate in the form in Part 1 of the Schedule (a "certificate of age"), specifying the age and deemed date of birth of the patient as so determined.
- (3) The date of birth for the time being entered in a certificate of age is to be treated as the patient's date of birth for the purposes of the Law, the Capacity Law and any enactment made under those Laws.
- (4) The persons mentioned in paragraph (2)(b) are –
  - (a) if the age determined is 16 years or over, the patient;
  - (b) subject to consent being given by the patient, the patient's nearest person; and
  - (c) in the case of a patient subject to guardianship, the guardian.
- (5) Where, subsequent to a determination under paragraph (2), the age of the patient is ascertained by reference to a Jersey register, the Minister must revoke the determination.
- (6) In any case other than that described in paragraph (4), where further evidence as to the age of the patient is produced to the Minister, the Minister may vary or revoke a determination under paragraph (2).

- (7) If the Minister varies or revokes a determination, the Minister must give notice of the variation or revocation to any person to whom a certificate of age, relating to that determination, has been issued.
- (8) In this Article –
- “Jersey register” means any book, certificate, entry, notice or register held at the Office of the Superintendent Registrar under the [Marriage and Civil Status \(Jersey\) Law 2001](#);
- “patient” includes a person lacking capacity, within the meaning of Part 1 of the Capacity Law, as to determination of his or her own age.

## 6 Prescribed forms

The following forms, which are set out in Part 2 of the Schedule, are those prescribed for the following purposes of the Law –

<i>Number identifying form in Schedule</i>	<i>Purpose (and Article of the Law) for which form is prescribed</i>
NP1	Nomination of nearest person by patient (Article 10(1))
NP2	Nomination of nearest person by Minister (Article 10(2))
NPRV	Revocation of nomination of nearest person (Article 10(5))
EA	Emergency authorization of admission (Article 15)
ND	Authorization by nurse of temporary detention (Article 17)
AA	Application for admission for assessment or for treatment (Articles 18, 21, 22)
JMRA	Joint medical recommendation for admission (Articles 18, 19, 21, 22)
SMRA	Single medical recommendation for admission (Articles 18, 19, 21, 22)
STL	Authorization of short term leave of absence (Article 24)
LTL	Authorization of long term leave of absence (Article 24)
DP	Direction for discharge of patient (Article 27)
RPWO	Return to detention of patient absent without leave (Article 28)
AG	Application for admission into guardianship (Article 29)
JMRG	Joint medical recommendation for guardianship (Article 29)
SMRG	Single medical recommendation for guardianship (Article 29)
GTAEG	Application for transfer of patient into guardianship (Article 32 and Regulation 4 of the <a href="#">Mental Health</a> )

	<a href="#">(Guardianship) (Jersey) Regulations 2018</a>
GTGAE	Application for transfer of patient to approved establishment from guardianship (Article 32 and Regulation 5 of the <a href="#">Mental Health (Guardianship) (Jersey) Regulations 2018</a> )
SOAD40	Certificate of patient's consent and of SOAD's opinion that patient is capable of consenting and that giving of treatment is appropriate (Article 40)
PC41	Certificate of patient's consent to treatment (Article 41)
SOAD41	Certificate of SOAD's opinion that patient has not consented to receive treatment or is not capable of consenting to treatment (Article 41)

## 7 Citation

This Order may be cited as the Mental Health (Miscellaneous Provisions and Prescribed Forms) (Jersey) Order 2018.

**SCHEDULE**

**PART 1**

(Article 5)

**FORM OF CERTIFICATE OF AGE**

**FORM OF CERTIFICATE OF AGE**

For the purposes of the [Mental Health \(Jersey\) Law 2016](#) and any Order made thereunder the Minister for Health and Social Services has determined the date of birth of (name of patient) to be the day of (date).

Signed .....

Minister for Health and Social Services

**PART 2**

(Article 6)

**FORMS PRESCRIBED FOR THE PURPOSES OF THE LAW**

FORM NP1

**Mental Health (Jersey) Law 2016****Article 10 (1) – Nomination of nearest person by the patient**

**Notes: Sections 1, 2 and 3** of this form are to be completed by a patient aged 18 or over who wants to nominate a person to be her or his nearest person. The patient can nominate more than one person and where the patient does so, must indicate the priority in which they are to act in **section 3.3**. Please provide a separate form for each nomination. **Section 4** of this form is to be completed by the person that is nominated.

If you have any questions as to the purpose of this form or need further guidance please speak to the ward manager.

**Section 1 – To be completed by the patient** (please give your details)

Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	

**Section 2 – The person nominated to be my nearest person** (please give their details)

Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	

FORM NP1

**Section 3 – Confirmation of the nomination of the nearest person** (please complete)

3.1	I confirm that I am 18 years or over and appoint the person detailed in Section 2 to be my nearest person (please tick)			
3.2	The appointment is subject to the following terms and condition, if any: (please detail below)			
3.3	Please indicate the priority of this nomination if there is more than one nearest person:	First <input type="checkbox"/>	Second <input type="checkbox"/>	Third <input type="checkbox"/>
Signed		Date		

**Section 4 – To be completed by the person nominated to be the nearest person** (please confirm the below)

4.1	I confirm that the contact details in Section 2 are correct		<input type="checkbox"/>
4.2	I confirm that I accept the terms and conditions (if any)		<input type="checkbox"/>
4.3	I confirm that I accept the nomination to be the nearest person for the patient detailed in Section 1		<input type="checkbox"/>
4.4	Name	Signed	Date

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018.

FORM NP2

**Mental Health (Jersey) Law 2016**

**Article 10(2)** Notice of nomination of nearest person by the Minister for Health and Social Services

**Notes:** This form enables the Minister for Health and Social Services to nominate a nearest person for a patient who lacks the capacity to do so or is under 18 years of age, and where it is not possible to identify a nearest person by any other means or to confirm that a person (who would otherwise be the patient's nearest person) is unable or unwilling to act as such.

**Section 1 – The patient**

URN	
Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	

**Section 2 – Person nominated to be the nearest person**

Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018.

FORM NP2

**Section 3 – Person authorised to nominate a nearest person on behalf of the Minister**

Title	
First Name	Second Name
Professional address	
Property name/number	
Road/lane	
Parish	
Post code	

I confirm that the above named patient:

3.1	is under 18 years of age, or	<input type="checkbox"/>
3.2	lacks the necessary capacity to make such an arrangement	<input type="checkbox"/>
and the patient's nearest relative:		
3.3	cannot be identified or	<input type="checkbox"/>
3.4	has confirmed in writing to the Minister that they are unable or unwilling to act as the patient's nearest person	<input type="checkbox"/>
3.5	and the nominated nearest person has consented to the role (Section 4)	<input type="checkbox"/>
Signed		Date

**Section 4 – Consent of the nominated nearest person**

Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	
I confirm that I accept the nomination to be the nearest person for the patient detailed above.	
Signed	
Date	



FORM NPRV

**Mental Health (Jersey) Law 2016****Article 10(5) Revocation of nomination of nearest person by the patient**

**Notes:** This form is to be completed by a patient who wants to stop someone they have nominated from continuing to act as their nearest person.

**Section 1 – To be completed by the patient** (please give your details)

Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	

**Section 2 – The person nominated to be the nearest person** (please give their details)

Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	

I confirm that I am revoking my nomination of the nearest person detailed in Section 2.

Signed	Date

Data Protection: The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

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FORM EA: THIS FORM IS TO BE USED FOR AN EMERGENCY APPLICATION ONLY



## Mental Health (Jersey) Law 2016

**Article 15** Emergency authorisation by an approved practitioner for admission for assessment

### Section 1 – The person authorising the admission

**Notes:** An authorization for immediate admission of a patient to an approved establishment must be made by an approved practitioner (see Article 15 (2)). The criteria to be met by an approved practitioner are detailed in Article 15 of the Law.

First Name	Second Name
Professional Address	
Property name/number	
Road/lane	
Parish	
Post code	
Telephone Number	

### Section 2 – The person to whom the application relates (the patient)

URN	
Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	
Date of birth	
Gender	Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/>

FORM EA: THIS FORM IS TO BE USED FOR AN EMERGENCY APPLICATION ONLY

**Section 3 – Grounds for admission** (please tick as appropriate)

3.1	I last examined the patient	Date		Time (24 hour)	
I confirm that in my opinion there is an urgent necessity for the patient to be admitted for assessment on the grounds that (please tick as appropriate):					
3.2	It is likely that the patient is suffering from a mental disorder, <b>and</b>				<input type="checkbox"/>
allowing the patient to remain at liberty would endanger					
3.3	the patient's safety <b>and/or</b>				<input type="checkbox"/>
3.4	the safety of other persons				<input type="checkbox"/>
3.5	My reasons for these opinions are: <i>(Your reasons should cover 3.3 and/or 3.4 above. As part of them describe the patient's symptoms and behaviour and explain why the patient ought to be admitted to hospital immediately and why informal admission is not appropriate)</i>				
3.6	Compliance with the provisions in Article 18 of the Law (general requirements for admission) would involve unreasonable delay, because:				
Signed		Date			
This authority for detention will expire after 72 hours (please complete below)					
Start Time (24hr)		Expiry date			
Expiry Time (24hr)					

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FORM EA: **THIS FORM IS TO BE USED FOR AN EMERGENCY APPLICATION ONLY**

**Section 4 – Expiry of detention**

Authorisation of detention under this Article expired because (please tick as appropriate)

4.1	72 hours has passed since authorisation	<input type="checkbox"/>
4.2	In my opinion as an approved practitioner the grounds for detention no longer apply in respect of the patient. <i>Please detail your opinion below:</i>	<input type="checkbox"/>
4.3	The patient was admitted for assessment (Article 21)	<input type="checkbox"/>
4.4	Date of admission for assessment	
4.5	The patient was admitted for treatment (Article 22)	<input type="checkbox"/>
4.6	Date of admission for treatment	
4.7	Full name	Signed
		Date of expiry
4.8	Time of expiry (24 hour)	

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018.

FORM ND

**Mental Health (Jersey) Law 2016****Article 17 – Detention by a nurse****Section 1 – The person authorising the detention**

**Notes:** Detention under this Article can only be authorized by a registered nurse.

The patient must be receiving treatment as an in-patient for a mental disorder in an approved establishment.

The patient can only be detained for **six hours**.

This can be extended by **one hour** by an approved practitioner (who must complete Section 3)

Notification of this authorization must be delivered to the manager of the approved establishment as soon as practicable

First Name	Second Name
Professional Address	
Property name/number	
Road/lane	
Parish	
Post code	
Telephone Number	

**Section 2 – Grounds for the detention**

It appears that (the grounds in 2.1 and 2.2 and 2.3 must all be met):			
2.1	the patient is suffering from a mental disorder and		<input type="checkbox"/>
2.2	to allow the patient to be at liberty would endanger the patient's safety <b>and/or</b>		<input type="checkbox"/>
	to allow the patient to be at liberty would endanger the safety of other persons		<input type="checkbox"/>
2.3	and it is not practicable to secure the immediate attendance of an approved practitioner		<input type="checkbox"/>
I last examined this patient on (date)			at time (24 hour)
Signed			

FORM ND

**Section 3 – Extension of detention by an approved practitioner and the outcome**

I examined the patient on (date)		at time (24 hour)	
<b>Outcome</b>			
3.1	The detention was extended for a further hour until time (24 hour)		
3.2	The detention expired at time (24 hour)		
3.3	An application was made for admission		<input type="checkbox"/>
Name		Signed	

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

Form AA

**Mental Health (Jersey) Law 2016**

Application for admission of a patient, under:  
(please select as appropriate)

**Article 21** Admission for Assessment ☐

**Article 22** Admission for Treatment ☐

**Section 1 – Authorized officer making the application**

An application for admission must be made by an authorized officer.

First Name	Second Name
Professional address	
Property name/number	
Road/lane	
Parish	
Post code	
Telephone Number	

**Section 2 - The patient to whom the application relates**

URN			
Title			
First Name	Second Name		
Address			
Property name/number			
Road/lane			
Parish			
Post code			
Date of birth			
Gender	Female <input type="checkbox"/>	Male <input type="checkbox"/>	Other <input type="checkbox"/>

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Form AA

**Section 3 – The grounds for admission** (please tick as appropriate)This application for **admission of the patient** is made on the grounds that:

<b>Article 21</b> Assessment	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 <b>OR</b>	<input type="checkbox"/>
<b>Article 22</b> Treatment	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	<input type="checkbox"/>
and it is necessary:		
3.1	in the interests of the patient's health and/or	<input type="checkbox"/>
	in the interests of the patient's safety and/or	<input type="checkbox"/>
3.2	for the protection of other persons	<input type="checkbox"/>
I confirm that I have informed the patient that this application is to be made		<input type="checkbox"/>
I last saw the patient within 7 days of this application on (date)		

**Section 4 – The details of the Nearest Person** (please complete and tick as appropriate)

First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	
Relationship with the patient	

If it has not been possible to identify a nearest person, please explain why below (please tick)		
4.1	Information not known	<input type="checkbox"/>
4.2	Patient does not have a nearest person as defined under Part 2 of the Law	<input type="checkbox"/>



Form AA

4.3	Any other reason (please indicate below):	
4.4	I have advised the nearest person of the patient that they can give notice in writing to the patient's responsible medical officer requesting exercise of the power to discharge the patient.	<input type="checkbox"/>
and		
4.5	consulted with the patient's nearest person or	<input type="checkbox"/>
4.6	consultation with the nearest person was not reasonable practicable or	<input type="checkbox"/>
4.7	consultation with the nearest person would have involved unreasonable delay	<input type="checkbox"/>

**Section 5 – Medical recommendations and signature**

This application is supported by two medical recommendations from:

Name	
Practice name	
Name	
Practice name	
<i>If neither of the medical practitioners had previous acquaintance with the patient before making recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient:</i>	

Signed	
Date	
Time (24hr)	

Form AA

**Section 6 – Record of admission**

**Notes:** this section is not part of the application, but it is to be completed at the approved establishment by the representative of the approved establishment.

PART ONE is for a new admission.

PART TWO is for the detention of a patient who has already been admitted.

PART THREE is to be filled in in all cases.

<b>PART ONE</b>	
Name of patient	
was admitted to (name of ward)	
within 72 hours of the time of application.	
Date of admission	
<b>Or</b>	
<b>PART TWO</b>	
Name of patient	
<b>was already in</b> (name of ward)	
on the date of application	
Date the application was received by me	
<b>PART THREE</b>	
Name of staff member	
Signature of staff member	
Date	
Time	

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018.

Form JMRA

**Mental Health (Jersey) Law 2016**

JOINT medical recommendation for admission for: (please select)

**Article 21** Assessment ☐**Article 22** Treatment ☐**Section 1 – The two registered medical practitioners making the application**  
(please complete and tick as appropriate)

**Notes:** An application for Assessment or Treatment must be accompanied by the recommendations of two registered medical practitioners, one of whom must also be an approved practitioner. The criteria for an approved practitioner are detailed in Article 16 of the Law.

One or both of the medical recommendations should, where practicable, be provided by a registered medical practitioner who has previous acquaintance with the patient.

Medical recommendations may not be given by a person who has a conflict of interest as provided for in Article 19(3) of the Law.

First Doctor		
First Name	Second Name	
Professional address		
Property name/number		
Road/lane		
Parish		
Post code		
I am a registered medical practitioner	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I am an approved practitioner	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have previous acquaintance with the patient	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I last examined this patient on (date)		

Form JMRA

Second Doctor			
First Name		Second Name	
Professional address			
Property name/number			
Road/lane			
Parish			
Post code			
I am a registered medical practitioner		Yes <input type="checkbox"/>	No <input type="checkbox"/>
I am an approved practitioner		Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have previous acquaintance with the patient		Yes <input type="checkbox"/>	No <input type="checkbox"/>
I last examined this patient on (date)			

**Section 2 – The patient to whom the recommendation relates**

URN			
Title			
First Name		Second Name	
Address			
Property name/number			
Road/lane			
Parish			
Post code			
Date of birth			
Gender	Female <input type="checkbox"/>	Male <input type="checkbox"/>	Other <input type="checkbox"/>

Form JMRA

**Section 3 – The grounds for admission** (Please select appropriate article)

Article 21 Assessment	In our opinion 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 <b>OR</b>	<input type="checkbox"/>
Article 22 Treatment	In our opinion 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	<input type="checkbox"/>

and it is necessary

(i)	in the interests of the patient's health, and/or	<input type="checkbox"/>
	in the interests of the patient's safety, and/or	<input type="checkbox"/>
(ii)	for the protection of other persons	<input type="checkbox"/>

Our reasons for these opinions are: *Your reasons should cover both (i) and (ii) above. As part of them: describe the patient's symptoms and behaviour; explain why the patient ought to be admitted to hospital and why informal admission is not appropriate.*

--

First Doctor signed		Date	
Second Doctor signed		Date	

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

Form SMRA

**Mental Health (Jersey) Law 2016**

SINGLE medical recommendation for admission for: (please select)

Article 21 Assessment ☐Article 22 Treatment ☐**Section 1 – The registered medical practitioner making the application**

**Notes:** An application for Assessment or Treatment must be accompanied by the recommendations of two registered medical practitioners (either joint or two single recommendations) one of whom must also be an approved practitioner. The criteria for an approved practitioner are detailed in Article 16 of the Law. At least one of the medical recommendations should where practicable, be provided by a registered medical practitioner who has previous acquaintance with the patient. Medical recommendations may not be given by a person who has a conflict of interest as provided for in Article 19(3)

**Single medical recommendations must be based on examinations that are not more than five days apart.**

First Name	Second Name		
Professional Address			
Property name/number			
Road/lane			
Parish			
Post code			
I am a registered medical practitioner	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
I am an approved practitioner	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
I have previous acquaintance with the patient	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
I last examined this patient on (date)			

Form SMRA

**Section 2 – The patient to whom the application relates**

URN	
Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	
Date of birth	
Gender	Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/>

**Section 3 – The grounds for admission (please select appropriate article)**

Article 21 Assessment	In my opinion 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 <b>OR</b>	<input type="checkbox"/>
Article 22 Treatment	In my opinion 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	<input type="checkbox"/>
and it is necessary		
(i)	in the interests of the patient's health, and/or	<input type="checkbox"/>
	in the interests of the patient's safety, and/or	<input type="checkbox"/>
(ii)	for the protection of other persons	<input type="checkbox"/>
My reasons for these opinions are: <i>Your reasons should cover both (i) and (ii) above. As part of them: describe the patient's symptoms and behaviour; explain why the patient ought to be admitted to hospital and why informal admission is not appropriate.</i>		
Signed		Date

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

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FORM STL

**Mental Health (Jersey) Law 2016****Article 24** Short term leave of absence from the approved establishment (less than 7 days)

I .....being the Responsible Medical Officer (RMO), grant to  
 ..... (patient's name) who is presently detained under Article ..... of the  
 Law from (date of detention) ..... leave to be absent from (ward) ....., as follows

**If it appears to the RMO it is necessary to do so, in the interests of your health or safety or for the protection of other persons, they can revoke the leave and recall you to the approved establishment**

Short term leave <b>within</b> the approved establishment grounds			
Start date		Finish date	
Minutes at a time		Occasions per day	
Conditions of leave (if any) are as follows (please tick as appropriate)			
Staff escorted leave <input type="checkbox"/> Family/friends escorted leave <input type="checkbox"/> Unescorted leave <input type="checkbox"/>			
Any other conditions			

Short term leave <b>outside</b> the approved establishment grounds					
Start date		Start Time (24 hour)		Finish date	
				Finish time (24 hour)	
Contact telephone number					
Conditions of leave (if any) are as follows (please tick as appropriate)					
Staff escorted leave <input type="checkbox"/> Family/friends escorted leave <input type="checkbox"/> Unescorted leave <input type="checkbox"/>					
Any other conditions					



## FORM STL

Overnight leave outside the approved establishment							
Start date		Start Time (24 hour)		Finish date		Finish time (24 hour)	
Overnight address							
Contact telephone number							
Conditions of leave (if any)							

Any breach of conditions or concerns should be reported to the ward Tel:	
Signed by RMO	Date

**Data protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

FORM LTL

**Mental Health (Jersey) Law 2016**

Article 24 Long term leave of absence from the approved establishment

I .....being the Responsible Medical Officer (RMO), grant to  
 ..... (patient's name) who is presently detained under Article ..... of the  
 Law from (date of detention)....., leave to be absent from (ward).....for the period

Start date		End date	
Indefinite leave (please detail the date the patient's detention expires)			
This authorisation for leave of more than 7 days is subject to the following conditions:			
1	If it appears to the RMO it is necessary to do so in the interests of your health or safety; or for the protection of other persons they can revoke the leave and recall you to the approved establishment.		
2	Whilst you are on leave, you will be required to continue to work with the team as described in your care plan, in particular by; <ul style="list-style-type: none"> <li>• attending appointments</li> <li>• allowing community staff to visit</li> <li>• complying with your treatment and medication plan</li> </ul>		
3	You must live at the following address:		
4	RMO comments:		
The Minister will be advised of this authorization and any variation in duration or conditions by submission of this form as necessary			
Signed (RMO)			Date
Signed (Patient)			Date

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018.

FORM DP

**Mental Health (Jersey) Law 2016****Article 27** Discharge of patient

**IMPORTANT NOTE:** This form cannot be used for a patient who is detained, under Article 68 of the Law, to protect the public from serious harm.

**Section One – The patient who is being discharged**

URN	
Title	
First Name	Second Name
Property name/ward	
Current Article under which the patient is detained	21 <input type="checkbox"/> 22 <input type="checkbox"/>

**Section two – Direction by the Responsible Medical Officer (RMO)**

First name		Second name	
Having regard to the care and supervision available to the patient if discharged, I the Registered Medical Officer detailed above, direct the discharge of the patient from the approved establishment in which they are detained.			
The patient is/will be (Please complete or tick as appropriate)			
2.1	Remaining in hospital as an informal patient	<input type="checkbox"/>	
2.2	Leaving hospital on the following date		
2.3	Already out on leave of absence	<input type="checkbox"/>	
I confirm that notice in writing of the discharge will be given to the patient, the patient's nearest person, the Minister and the managers of the approved establishment as soon as reasonably practicable.			
Date of discharge		Time (24hr)	
Signed by RMO			

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018.

FORM RPWO

**Mental Health (Jersey) Law 2016****Article 28** Return of patient absent without leave

**Notes:** This form is to be used for a patient who is absent without leave for more than 28 days but returns within six months. If six months have elapsed, the patient is no longer liable to be detained (Article 25 and Article 31).

**Section 1 – The person to whom the report relates (the patient)**

URN	
Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	

**Section 2 – The Registered Medical Officer reporting to the Minister**

First Name	Second Name
Professional address	
Property name/number	
Road/lane	
Parish	
Post code	
Telephone Number	

## FORM RPWO

**Section 3 – The grounds for detention of the patient** (please date and tick as appropriate)

3.1	Date of patient's return	
3.2	Date of patient's examination (within one week of return)	
I have examined the patient and consulted the following people concerned with the patient's care or treatment		
3.3	Nearest person	<input type="checkbox"/>
3.4	General Practitioner	<input type="checkbox"/>
3.5	Approved Medical Practitioner	<input type="checkbox"/>
3.6	Other (please detail)	
It appears to me, as the above named Responsible Medical Officer, that the patient appears to be suffering from mental disorder of a nature or degree which warrants:		
3.7	the detention of the patient in an approved establishment for treatment, or	<input type="checkbox"/>
3.8	the reception of the patient into guardianship; and	<input type="checkbox"/>
it is necessary		
3.9	in the interests of the patient's health or	<input type="checkbox"/>
3.10	in the interests of the patient's safety or	<input type="checkbox"/>
3.11	for the protection of other persons	<input type="checkbox"/>
3.12	that the patient should be so detained or received	
Signed		Date

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

FORM AG

**Mental Health (Jersey) Law 1969****Article 29** Application for Guardianship**Section 1 – the person making the application**

**Notes:** An application for the reception of a patient into guardianship must be made by an authorized officer (Article 29(2) of the Law).

Please note **Section 3.3** must be signed by a private guardian.

First Name	Second Name
Professional address	
Property name/number	
Road/lane	
Parish	
Post code	

**Section 2 – the person who is to be received into guardianship**

URN			
Title			
First Name	Second Name		
Address			
Property name/number			
Road/lane			
Parish			
Post code			
Date of birth			
Gender (please tick)	Female <input type="checkbox"/>	Male <input type="checkbox"/>	Other <input type="checkbox"/>

## FORM AG

**Section 3 – the proposed guardian** (please tick or complete as appropriate)3.1: The Minister ☐

3.2: Private guardian as below

First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	
Telephone Number	

3.3 This part is to be completed by any private guardian

I consent to act as the guardian of the above named patient in accordance with the Law.			
Signed		Date	

**Section 4 – Consultation with the nearest person**

4.1 In accordance with the Law, I have consulted

First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	
Telephone Number	

## FORM AG

To be completed if the nearest person has not been consulted (please tick)		
4.2	I have been unable to ascertain who is this patient's nearest person within the meaning of the Law	<input type="checkbox"/>
4.3	To the best of my knowledge and belief this patient has no nearest person within the meaning of the Law	<input type="checkbox"/>
4.4	In my opinion it is	
	• not reasonably practicable or	<input type="checkbox"/>
	• would involve unreasonable delay	<input type="checkbox"/>
to consult that person before making this application because (please give reasons below):		

## Section 5 – Grounds for guardianship

5.1	I have personally seen the patient	<input type="checkbox"/>
	Date of contact:	
5.2	This application is accompanied by two medical recommendations in the prescribed form.	<input type="checkbox"/>
5.3	<i>If neither of the medical practitioners had previous acquaintance with the patient before making their recommendations, please explain why you could not get a recommendation from a medical practitioner who did have previous acquaintance with the patient</i>	
5.4	Please indicate the length of guardianship applied for:	
5.5	First application (six months)	<input type="checkbox"/>
5.6	Second application (six months)	<input type="checkbox"/>
5.7	Successive twelve month period	<input type="checkbox"/>
Signed		Date

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018



FORM JMRG

**Mental Health (Jersey) Law 2016****Article 29** JOINT medical recommendation for guardianship**Section 1 – The two registered medical practitioners making the recommendation**

**Notes:** The medical recommendation must be completed by two registered medical practitioners (RMP) who have examined the patient together, at least one of whom must be an approved officer as defined by Article 16 of the Law. At least one of the registered medical practitioners should have previous acquaintance with the patient.

First Registered Medical Practitioner		
First Name	Second Name	
Professional address		
Property name/number		
Road/lane		
Parish		
Post code		
I am a registered medical practitioner	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I am an approved practitioner	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have previous acquaintance with the patient	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I last examined this patient on (date)		

## FORM JMRG

Second Registered Medical Practitioner			
First Name		Second Name	
Professional address			
Property name/number			
Road/lane			
Parish			
Post code			
I am a registered medical practitioner		Yes <input type="checkbox"/>	No <input type="checkbox"/>
I am an approved practitioner		Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have previous acquaintance with the patient		Yes <input type="checkbox"/>	No <input type="checkbox"/>
I last examined this patient on (date)			

**Section 2 – The person to whom the application relates**

URN			
Title			
First Name		Second Name	
Address			
Property name/number			
Road/lane			
Parish			
Post code			
Date of birth			
Gender	Female <input type="checkbox"/>	Male <input type="checkbox"/>	Other <input type="checkbox"/>

## FORM JMRG

**Section 3 – the grounds for guardianship** (please date and tick as appropriate)

In our opinion the patient appears to be suffering from mental disorder of a nature or degree which warrants the reception of the person into guardianship and the patient should be subject to guardianship	<input type="checkbox"/>
(i) in the interests of the patient's welfare or	<input type="checkbox"/>
(ii) for the protection of other persons	<input type="checkbox"/>
Our reasons for these opinions are: (Your reasons should cover both (i) and (ii) above. <i>Describe the patient's symptoms and behaviour and explain why the patient cannot be cared for appropriately without the use of guardianship powers</i> )	
First RMP signed	Date
Second RMP signed	Date

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

FORM SMRG

**Mental Health (Jersey) Law 2016****Article 29** SINGLE medical recommendation for guardianship**Section 1 – The registered medical practitioner making the recommendation**

**Notes:** The medical recommendation must be completed by a registered medical practitioner. At least one of the two recommendations required must be provided by an approved officer as defined by Article 16 of the Law. At least one of the registered medical practitioners should have previous acquaintance with the patient where practicable (Article 19(2) of the Law).

**Separate recommendations must be based on examinations that are**

First Name	Second Name		
Professional address			
Property name/number			
Road/lane			
Parish			
Post code			
I am a registered medical practitioner	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
I am an approved practitioner	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
I have previous acquaintance with the patient	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
I last examined this patient on (date)			

## FORM SMRG

**Section 2 – The person to whom the application relates**

URN	
Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	
Date of birth	
Gender	Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/>

**Section 3 – The grounds for guardianship** (please date and tick as appropriate)

In my opinion the patient appears to be suffering from mental disorder of a nature or degree which warrants the reception of the person into guardianship and it is necessary for the patient to be received into guardianship	<input type="checkbox"/>
(i) in the interests of the patient's welfare and/or	<input type="checkbox"/>
(ii) for the protection of other persons	<input type="checkbox"/>
My reasons for these opinions are; <i>(Your reasons should cover both (i) and (ii) above. Describe the patient's symptoms and behaviour and explain why the patient cannot be cared for appropriately without the use of guardianship powers)</i>	
Signed	Date

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

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FORM GTAEG

**Mental Health (Guardianship) (Jersey) Regulations 2018**

**Regulation 4**                      Transfer of a patient into guardianship from an approved establishment

**Section 1 – the person making the application for transfer**

**Notes:** The application for transfer must be made by an authorized officer who has personally seen the patient. They must have consulted with the nearest person unless this is not practicable or would involve unreasonable delay. The application incorporates the recommendation of the approved practitioner (section 2) and the consent of the guardian (section 4), both of which must be completed.

First Name	Second Name
Professional address	
Property name/number	
Road/lane	
Parish	
Post code	

**Section 2 – the approved practitioner providing the recommendation**

First Name	Second Name
Professional address	
Property name/number	
Road/lane	
Parish	
Post code	

## FORM GTAEG

**Section 3 – the patient to whom this application applies**

URN	
Title	
First Name	Second Name
Property name/ward	

**Section 4 – The details of the guardian**

Title	
First Name	Second Name
Address	
Property name/number	
Road/lane	
Parish	
Post code	

4.1 This part is to be completed by the guardian

I consent to act as the guardian of the above named patient in accordance with the Law.			
Signed		Date	

**Section 5 – the opinion of the approved practitioner (please tick as appropriate)**

5.1	I confirm that I am the approved practitioner detailed at section 2 above	<input type="checkbox"/>
5.2	I last examined the patient with a view to making a medical recommendation on the following date which is within seven days of this application	
5.3	Date of examination	
In my opinion the following grounds are met:		
5.4	the patient appears to be suffering from a mental disorder of a nature or degree which warrants the reception of the patient into guardianship <b>and</b>	<input type="checkbox"/>
5.5	It is necessary in the interests of the patient's welfare for the patient to be transferred from the approved establishment in which they are detained, and received into guardianship	<input type="checkbox"/>

## FORM GTAEG

5.6	My reasons for these opinions are: <i>(Your reasons should cover both 5.4 and 5.5 above. As part of them: describe the patient's symptoms and behaviour and explain why the patient cannot be cared for appropriately without the use of guardianship powers)</i>				
Signed		Date		Time (24 hr)	

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018



FORM GTGAE

**Mental Health (Guardianship) (Jersey) Regulations 2018**

**Regulation 5** Application for transfer of patient to approved establishment from guardianship

**Section 1 – The person making the application for transfer**

**Notes:** The application for transfer must be made by an authorized officer who has consulted with the responsible medical officer and, if practicable, the nearest person.

Approved establishment means an establishment or premises approved by the Minister under the Mental Health (Jersey) Law 2016 Article 5 .

First Name	Second Name
Professional address	
Property name/number	
Road/lane	
Parish	
Post code	

**Section 2 – The patient and guardian to whom this application applies**

URN	
Title	
First Name	Second Name
<b>Guardian</b>	
Name of guardian	
Property name/ward	

## FORM GTGAE

**Section 3 – The details of the approved establishment**

Name	
Telephone Number	
Manager (full name)	
3.1	I confirm that I consent to the transfer, and
3.2	I have made arrangements sufficient to enable the admission of the patient to the approved establishment within 14 days.
Signed	
Date	

**Section 4 – Consultation and grounds for transfer (please tick as appropriate)**

Having consulted with:			
4.1	the patient's responsible medical officer,	<input type="checkbox"/>	
First name		Second name	
4.2	the patient's nearest person	<input type="checkbox"/>	
First name		Second name	
4.3	If it has not been possible to consult with the patient's nearest person please indicate the reason below:		
4.4	consultation is not reasonably practicable	<input type="checkbox"/>	
4.5	consultation would involve unreasonable delay	<input type="checkbox"/>	
In my opinion the grounds below are met:			
The existing arrangements made for the patient under guardianship do not provide or have ceased to provide an environment that is:			
4.6	conducive to the further assessment or treatment of the patient for the purposes preventing a deterioration in the patient's mental illness and condition, or	<input type="checkbox"/>	
4.7	appropriate having regard to the need for protection of other persons	<input type="checkbox"/>	
4.8	Date of personally seeing the patient		
Signed		Date	Time (24 hr)

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

SOAD40

**Mental Health (Jersey) Law 2016****SECOND OPINION APPROVED DOCTOR (SOAD) CERTIFICATE  
AND CERTIFICATE OF PATIENT CONSENT****Article 40** Treatment requiring both consent and a second opinion

**Notes:** This certificate must be provided by a Second Opinion Approved Doctor (SOAD) appointed for the purposes of PART 6 of the Law, and must include the patient's consent (**section 1**)

The types of treatment covered by the certificate are detailed in Article 40 of the law.

The certificate must be transmitted to the Responsible Medical Officer on completion.

**Section 1 – The patient to whom this certificate relates**

URN			
Title			
First Name	Second Name		
Property /Ward			
I confirm that I, the patient, understand the nature, purpose and likely effects of the treatment and consent to receive it.			
Signed		Date	

SOAD40

**Section 2 – The SOAD providing certification** (please tick and complete as appropriate)

Having consulted with:			
2.1	the patient's responsible medical officer, and	<input type="checkbox"/>	
2.2	an authorized officer or	<input type="checkbox"/>	
2.3	mental health professional	<input type="checkbox"/>	
who is or has been professionally concerned with the treatment of the patient			
I certify that:			
2.4	the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment and	<input type="checkbox"/>	
2.5	the patient has consented to receive it and	<input type="checkbox"/>	
2.6	it is appropriate for the treatment to be given to the patient	<input type="checkbox"/>	
<i>Give a description of the treatment or plan of treatment. Indicate clearly if the certificate applies to part or all of the treatment and whether it is for a specific period of time.</i>			
First name		Second name	
Signed		Date	
Date the certificate is to expire (six months maximum)			

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

FORM PC41

**Mental Health (Jersey) Law 2016****CERTIFICATE OF PATIENT CONSENT****Article 41** Treatment requiring either consent or a second opinion

**Notes:** This certificate must be provided by either the patient's responsible medical officer or any other approved practitioner. **This certificate is valid for a maximum of six months.**

Treatment requiring consent in this form includes the administration of medicine to the patient at any time during their detention if 3 months or more have elapsed since the first occasion the medicine was administered.

**Section 1 – The patient to whom this certificate relates**

URN			
Title			
First Name	Second Name		
Property /Ward			
I confirm that I, the patient, understand the nature, purpose and likely effects of the treatment and consent to receive it.			
Signed		Date	

**Section 2 – The Registered Medical Practitioner providing certification**

Responsible medical officer <input type="checkbox"/> Approved practitioner <input type="checkbox"/>			
First Name		Second Name	
I certify that the patient			
a	is capable of understanding the nature, purpose and likely effects of the proposed treatment	<input type="checkbox"/>	
b	has consented to receive it	<input type="checkbox"/>	
Signed		Date	
Date the certificate is to expire (six months maximum)			

Data Protection: The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

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SOAD41

**Mental Health (Jersey) Law 2016****SECOND OPINION APPROVED DOCTOR (SOAD) CERTIFICATE****Article 41** Treatment requiring either consent or a second opinion

**Notes:** This certificate must be provided by a Second Opinion Approved Doctor (SOAD) appointed for the purposes of PART 6 of the Law. The criteria to be met by a SOAD are detailed in Article 38 (3) of the Law. **This certificate is valid for a maximum of six months.**

**Section 1 – The patient to whom this certificate relates**

URN	
Title	
First Name	Second Name
Property /Ward	

**Section 2 – The SOAD providing certification** (please tick as appropriate)

Having consulted with:			
2.1	the patient's responsible medical officer,		<input type="checkbox"/>
	First name	Second name	
2.2	an authorized officer or		<input type="checkbox"/>
2.3	mental health professional		<input type="checkbox"/>
	First name	Second name	
who is or has been responsible for the treatment of the patient			
I certify that the patient			
2.4	is <b>not</b> capable of understanding the nature, purpose and likely effects of the proposed treatment or		<input type="checkbox"/>
2.5	has <b>not</b> consented to receive it <b>but</b> (continue overleaf)		<input type="checkbox"/>

SOAD41

2.6	having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition, the treatment should be given to the patient	<input type="checkbox"/>
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Give a description of the treatment or plan of treatment below. When giving reasons for the treatment please indicate whether in your opinion, disclosure of the reasons would be likely to cause serious harm to the physical or mental health of the patient or to that of any other person.

First name		Second name	
Signed		Date	
Date the certificate is to expire (six months maximum)			

**Data Protection:** The data provided will be processed in accordance with the Data Protection (Jersey) Law 2018

## ENDNOTES

### Table of Legislation History

Legislation	Year and No	Commencement
Mental Health (Miscellaneous Provisions and Prescribed Forms) (Jersey) Order 2018	<a href="#">R&amp;O.98/2018</a>	1 October 2018
Mental Health (Miscellaneous Provisions and Prescribed Forms) (Amendment) (Jersey) Order 2019	<a href="#">R&amp;O.57/2019</a>	10 July 2019

### Table of Endnote References

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<sup>1</sup> *Article 3* substituted by *R&O.57/2019*