APPLICATION TO MENTAL HEALTH REVIEW TRIBUNAL
Mental Health (Jersey) Law 2016 (MHJL)

Please try to complete all the information on the form – if you are unsure of anything the tribunal can assist you to find out the information. We may have to contact you to check the details if there are some parts missing.

If you are completing this form on behalf of someone else please use this section to fill out the details of the person who is detained / has their liberty restricted

Your full name	
Home Address	
Date of Birth	
Is someone assisting you to complete this form	☐ Yes ☐ No
Do you consent to the Tribunal disclosing your information to the person helping you fill out the form?	☐ Yes ☐ No
Is the patient the applicant?	☐ Yes ☐ No
If No, please specify who is:	
Address	

If you have assisted the Patient to complete this form, please complete Section 1 at the end of this form

Application under the Mental Health Law

Please tick the relevant application type

Detention under an assessment authorization Article 21 (28 day assessment order)		Detention in custody following absence without leave *(this is where you left without authorisation)*	
Detention under a treatment authorization Article 22 *(detention or renewal)*		Exercise of power to recall from absence *(this is where you have been recalled from leave)*	
Guardianship *(first application or renewal)*		Decision by Managers to restrict communications	
Treatment Order *(An Order set down by the Royal Court)*		Challenging an off Island transfer from Jersey	

Please give the reasons for your application (The more information you can give will assist your lawyer in helping you)	

What outcome would you like from your appeal?	

Details and circumstances of detention/Decision

If you have a copy of the decision letter please attach it to this form, otherwise tick this box for the Tribunal to request a copy on your behalf ☐

Detention in an approved establishment (if you do not know the date or address the tribunal can assist)	
Name and Address of Establishment or Hospital	
Date of detention/decision that you wish to appeal	

Sharing of Information

Nearest person / Nearest Relative	
Name	
Address	
Telephone / Email	
Relationship to you	
Do you agree to the Tribunal:	
Informing the person named above of your appeal?	☐ Yes ☐ No
Giving information or documents (such as medical records, reports etc) if the person names above asks for these.	☐ Yes ☐ No
Allowing the person named above to attend the hearing	☐ Yes ☐ No
Independent Advocacy	
Do you have the support of the Independent Mental Health Advocacy Service (IMHA)?	☐ Yes ☐ No
If Yes, give their name	

Do you want the IMHA informed of the date of a hearing?	☐ Yes ☐ No
Do you give permission for the IMHA to discuss matters with your lawyer	☐ Yes ☐ No
<u>Legal Representation</u> **You are entitled to free legal representation**	
Would you like a legal representative to be appointed on your behalf	☐ Yes ☐ No
Have you previously been represented at the Tribunal	☐ Yes ☐ No
If yes, give name of Lawyer	
<u>Interpreters or other special requirements</u>	
Do you require an interpreter?	☐ Yes ☐ No
If so, please enter the language and dialect required	
Please provide details of any other special requirements which you consider necessary to ensure you can participate fully in the proceedings	

Section 6 – Declaration and signature (Please tick)

☐ This application is submitted by myself or nearest person/relative (*delete as appropriate) and I have capacity to apply and instruct a lawyer.*

☐ This application is submitted on my own behalf and I may need support to access the Tribunal and understand the process.

☐ This application is submitted on behalf of the patient, who has personally authorised me to submit this application on their behalf

Signature		**Date**	
Print name			

Completed forms should be sent to:

Email: Mentalhealthreviewtribunal@courts.je or

Posted to MHRT, First Floor, International House, 41 The Parade, St Helier JE2 3QQ

SECTION 1

To be completed by individual supporting or assisting the patient to complete the application or where the form has been completed on the patient's behalf

The Tribunal understands that capacity is time and decision specific and that the individual does not necessarily need to fully understand the Tribunal process, just that the Tribunal can provide a means of resolving the situation – in this case challenging a restriction on their liberty

Your Name:	
Relationship/role:	
Contact details: (Tel and Email)	
Does the patient have capacity to apply to the Tribunal on their own behalf?	☐ Yes ☐ No ☐ Unknown
If an individual wishes to challenge their detention or a decision, but requires extra support to do so please briefly explain what steps have been taken to support the patient in making the decision to apply to the Tribunal for themselves	
If there are specific steps that the Tribunal or legal representative should take to assist the patient to participate fully, this can be included here.	
please explain why an application to the Tribunal is considered to be in the patient's best interests	
Do you consider it likely that the patient will regain capacity at some point during the proceedings?	☐ Yes ☐ No ☐ Unknown

If the patient does not have capacity to consent to notice or disclosure (as described in the form above) please explain why you consider the provision of such notice or disclosure to be in the patient's best interests (if applicable)	

Does the patient have capacity to instruct a legal representative?	☐ Yes ☐ No