TRIBUNALS
JUDICIARY

PRACTICE DIRECTION

FIRST-TIER TRIBUNAL

HEALTH EDUCATION AND SOCIAL CARE CHAMBER

STATEMENTS AND REPORTS IN MENTAL HEALTH CASES

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1. This practice direction is made by the Senior President of Tribunals with the agreement of the Lord Chancellor in the exercise of powers conferred by section 23 of the Tribunals, Courts and Enforcement Act 2007. It applies to a “mental health case” as defined in rule 1(3) the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008. Rule 32 requires that certain documents are to be sent or delivered to the tribunal (and, in restricted cases, to the Secretary of State) by the responsible authority, the responsible clinician and any social supervisor (as the case may be). This practice direction specifies the contents of the statements and the reports that are to be sent or delivered in accordance with rule 32. It replaces the previous Practice Direction on mental health cases dated 30 October 2008 with effect from 06 April 2012.

2. In this practice direction “the Act” refers to the Mental Health Act 1983, as amended.

A. IN-PATIENTS

3. For the purposes of this practice direction, a patient is an in-patient if they are in hospital to be assessed or treated for a mental disorder, even if treatment is being provided informally, or under a provision other than that to which the application or reference to the tribunal relates.

4. A patient is also an in-patient if they are detained in hospital through the criminal justice system, or if they have been transferred to hospital from a custodial establishment. This includes patients detained under a hospital order or removed to hospital from prison - whether or not the patient is also a restricted patient.

5. In the case of a restricted patient detained in hospital, the tribunal may make a provisional decision to order a conditional discharge. Before it finally grants a conditional discharge, the tribunal may defer its decision so that arrangements to its satisfaction can be put in place. Unless and until the tribunal finally grants a conditional discharge, the patient remains an in-patient, and so this part of the practice direction applies.

6. If the patient is an in-patient, the responsible authority must send or deliver to the tribunal the following documents containing the specified information in accordance with paragraphs 7 or 8 below, as appropriate:

i) Statement of Information about the Patient

ii) Responsible Clinician's Report

iii) In-Patient Nursing Report [A copy of the patient's current nursing plan must be appended to the report.]

iv) Social Circumstances Report

7. In all cases **except where a patient is detained under section 2 of the Act**, the responsible authority must send or deliver to the tribunal the required documents, containing the specified information, so that the documents are received by the tribunal as soon as practicable and in any event within 3 weeks after the responsible authority made the reference or received a copy of the application or reference. If the patient is a restricted patient, the responsible authority must also, at the same time, send copies of the documents to the Secretary of State.

8. **Where a patient is detained under section 2 of the Act**, the responsible authority must prepare the required documents as soon as practicable after receipt of a copy of the application or a request from the tribunal. It may be that some of the specified information will not be immediately available. The responsible authority must balance the need for speed with the need to provide as much of the specified information as possible within the time available. If information is omitted because it is not available, then that should be mentioned in the relevant document. These documents must be made available to the tribunal panel and representative at least one hour ahead of the hearing.

<u>i) Statement of Information about the Patient</u>

9. The statement provided to the tribunal must, in so far as it is within the knowledge of the responsible authority, include the following up-to-date information:

a) the patient's full name (and any alternative names used in their patient records);
b) the patient's date of birth, age and usual place of residence;
c) the patient's first language and, if it is not English, whether an interpreter is required and, if so, in which language;
d) if the patient is deaf, whether the patient will require the services of a British Sign Language interpreter or a Relay Interpreter;
e) the date of admission or transfer of the patient to the hospital in which the patient is detained or liable to be detained, together with details of the application, order or direction that is the original authority for the detention of the patient, and details of any subsequent renewal of, or change in, the authority for detention;
f) details of the hospital at which the patient is detained;
g) details of any transfers between hospitals since the original application, order or direction was made;
h) where the patient is detained in an independent hospital, details of any NHS body that funds, or will fund, the placement;
i) the name of the patient's responsible clinician and the date when the patient came under the care of that clinician;

j) the name and address of the local social services authority and NHS body which, were the patient to leave hospital, would have the duty to provide after-care services for the patient under section 117 of the Act;
k) the name of any care co-ordinator appointed for the patient;
l) except in the case of a restricted patient, the name and address of the patient's nearest relative or of the person exercising that function, whether the patient has made any specific requests that their nearest relative should not be consulted or should not be kept informed about the patient's care or treatment and, if so, the detail of any such requests and whether the responsible authority believes that the patient has capacity to make such requests;
m) the name and address of any person who plays a significant part in the care of the patient but who is not professionally concerned with that care;
n) the name and address of any deputy or attorney appointed for the patient under the Mental Capacity Act 2005;
o) details of any registered lasting or enduring power of attorney made by the patient;
p) details of any existing advance decisions made by the patient to refuse treatment for mental disorder.

ii) Responsible Clinician's Report

10. This report must be up-to-date and specifically prepared for the use of the tribunal. Unless it is not reasonably practicable, the report must be written or counter-signed by the patient's responsible clinician and must describe the patient's relevant medical history and current presentation, including:

a) full details of the patient's mental state, behaviour and treatment for mental disorder;
b) so far as it is within the knowledge of the person writing the report, a statement as to whether, at a time when the patient was mentally disordered, the patient has neglected or harmed themselves or threatened themselves with harm, or has harmed other persons or threatened them with harm, or damaged property or threatened to damage property, together with details of any neglect, harm, damage or threats;
c) an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient were to be discharged by the tribunal, and how any such risks could be managed effectively;
d) an assessment of the patient's strengths and any other positive factors of which the tribunal should be aware;
e) whether the patient has a learning disability that may adversely affect their understanding or ability to cope with the tribunal hearing, and whether there are any approaches or adjustments that the panel may consider in order to deal with the case fairly and justly.

iii) In-Patient Nursing Report

11. This report must be up-to-date and specifically prepared for the use of the tribunal. In relation to the patient's current in-patient episode it must include full details of the following:

a) the patient's understanding of, and willingness to accept, the current treatment for mental disorder provided or offered;
b) the level of observation to which the patient is subject;

c) any occasions on which the patient has been secluded or restrained, including the reasons why seclusion or restraint was considered to be necessary;
d) any occasions on which the patient has been absent without leave whilst liable to be detained, or occasions when the patient has failed to return when required, after having been granted leave of absence;
e) any incidents where the patient has harmed themselves or others or threatened such harm, or damaged property or threatened such damage.

iv) Social Circumstances Report

12. This report must be up-to-date and specifically prepared for the use of the tribunal. It must include full details of the following:

a) the patient's home and family circumstances, and the housing facilities available;
b) so far as it is practicable, **and except in restricted cases**, a summary of the views of the patient's nearest relative unless (having consulted the patient) the person compiling the report considers that it would be inappropriate to consult the nearest relative;
c) so far as it is practicable, the views of any person who plays a significant part in the care of the patient but is not professionally concerned with it;
d) the views of the patient, including the patient's concerns, hopes and beliefs;
e) the opportunities for employment available to the patient;
f) what (if any) community support or after-care is being, or would be, made available to the patient, and the author's views as to its likely effectiveness were the patient to be discharged from hospital;
g) the patient's financial circumstances (including entitlement to benefits);
h) an assessment of the patient's strengths and any other positive factors of which the tribunal should be aware;
i) an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient were to be discharged from hospital, and how any such risks could be managed effectively.

B. COMMUNITY PATIENTS

13. If the patient is a community patient under section 17A of the Act the responsible authority must send or deliver to the tribunal the following documents, containing the specified information, so that the documents are received by the tribunal as soon as practicable and in any event within 3 weeks after the responsible authority made the reference or received a copy of the application or reference:

i) Statement of Information about the Patient

ii) Responsible Clinician's Report

iii) Social Circumstances Report

i) Statement of Information about the Patient

14. The statement provided to the tribunal must, in so far as it is within the knowledge of the responsible authority, include the following up-to-date information:

a) the patient's full name (and any alternative names used in their patient records);
b) the patient's date of birth, age and usual place of residence;
c) the patient's first language and, if it is not English, whether an interpreter is required and, if so, in which language;
d) if the patient is deaf, whether the patient will require the services of a British Sign Language interpreter or a relay interpreter;
e) details of the place where the patient is living;
f) the name of the patient's responsible clinician and the date when the patient came under the care of that clinician;
g) the name and address of the local social services authority and NHS body having a duty to provide after-care services for the patient under section 117 of the Act;
h) the name of any care co-ordinator appointed for the patient;
i) the name and address of the patient's nearest relative or of the person exercising that function, whether the patient has made any specific requests that their nearest relative should not be consulted or should not be kept informed about the patient's care or treatment and, if so, the detail of any such requests and whether the responsible authority believes that the patient has capacity to make such requests;
j) the name and address of any deputy or attorney appointed for the patient under the Mental Capacity Act 2005;
k) details of any registered lasting or enduring power of attorney made by the patient;
l) details of any existing advance decisions made by the patient to refuse treatment for mental disorder.

ii) Responsible Clinician's Report

15. This report must be up-to-date and specifically prepared for the use of the tribunal. Unless it is not reasonably practicable, the report must be written or counter-signed by the patient's responsible clinician and must describe the patient's relevant medical history and current presentation, including:

a) where the case is a reference to the tribunal, an assessment of the patient's capacity to decide whether or not to attend, or be represented at, a hearing of the reference;
b) whether the patient has a learning disability that may adversely affect their understanding or ability to cope with the tribunal hearing, and whether there are any approaches or adjustments that the panel may consider in order to deal with the case fairly and justly.
c) details of the date of, and circumstances leading up to, the patient's underlying section 3 order, and a brief account of when, and why, the patient then came to be subject to a community treatment order;
d) full details of the patient's mental state, behaviour and treatment for mental disorder, and relevant medical history;
e) so far as it is within the knowledge of the person writing the report, a statement as to whether, at a time when the patient was mentally disordered, the patient has neglected or harmed themselves or threatened themselves

with harm, or has harmed other persons or threatened them with harm, or damaged property or threatened to damage property, together with details of any neglect, harm, damage or threats;
f) an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient were to be discharged by the tribunal, and how any such risks could be managed effectively;
g) an assessment of the patient's strengths and any other positive factors of which the tribunal should be aware;
h) the reasons why it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) of the Act to recall the patient to hospital;
i) any conditions to which the patient is subject under section 17B of the Act.

iii) Social Circumstances Report

16. This report must be up-to-date and specifically prepared for the use of the tribunal. It must include full details of the following:

a) the patient's home and family circumstances, and the housing facilities available;
b) so far as it is practicable a summary of the views of the patient's nearest relative, unless (having consulted the patient) the person compiling the report considers that it would inappropriate to consult the nearest relative;
c) the views of any person who plays a significant part in the care of the patient but is not professionally concerned with that care;
d) the views of the patient, including their concerns, hopes and beliefs;
e) the opportunities for employment available to the patient;
f) what (if any) community support or after-care is being, or would be, made available to the patient, and the author's views as to its likely effectiveness were the community treatment order to continue, or were it to be discharged;
g) the patient's financial circumstances (including entitlement to benefits);
h) an assessment of the patient's strengths and any other positive factors of which the tribunal should be aware;
i) an account of the patient's progress whilst a community patient, details of any conditions or requirements to which the patient is subject under the community treatment order, and details of any behaviour that has put the patient or others at risk;
j) an assessment of the extent to which the patient or other persons would be likely to be at risk if the tribunal were to discharge the community treatment order.

C. GUARDIANSHIP PATIENTS

17. If the patient has been received into guardianship under section 7 of the Act, the responsible authority must send or deliver to the tribunal the following documents, containing the specified information, so that the documents are received by the tribunal as soon as practicable and in any event within 3 weeks after the responsible authority made the reference or received a copy of the application or reference:

i) Statement of Information about the Patient

ii) Responsible Clinician's Report

iii) Social Circumstances Report

i) Statement of Information about the Patient

18. The statement provided to the tribunal must, in so far as it is within the knowledge of the responsible authority, include the following up-to-date information:

a) the patient's full name (and any alternative names used in their patient records);
b) the patient's date of birth, age and usual place of residence;
c) the patient's first language and, if it is not English, whether an interpreter is required and, if so, in which language;
d) if the patient is deaf, whether the patient will require the services of a British Sign Language interpreter or a Relay Interpreter;
e) the date of the reception of the patient into guardianship, together with details of the application, order or direction that constitutes the original authority for the guardianship of the patient;
f) where the patient is subject to the guardianship of a private guardian, the name and address of that guardian;
g) the name of the patient's responsible clinician and the date when the patient came under the care of that clinician;
h) details of the place where the patient is living;
i) the name of any care co-ordinator appointed for the patient;
j) the name and address of the patient's nearest relative or of the person exercising that function, whether the patient has made any specific requests that their nearest relative should not be consulted or should not be kept informed about the patient's care or treatment and, if so, the detail of any such requests and whether the responsible authority believes that the patient has capacity to make such requests;
k) the name and address of any person who plays a significant part in the care of the patient but who is not professionally concerned with that care;
l) the name and address of any deputy or attorney appointed for the patient under the Mental Capacity Act 2005;
m) details of any registered lasting or enduring power of attorney made by the patient;
n) details of any existing advance decisions made by the patient to refuse treatment for mental disorder.

ii) Responsible Clinician's Report

19. This report must be up-to-date and specifically prepared for the use of the tribunal. Unless it is not reasonably practicable, the report must be written or counter-signed by the patient's responsible clinician and must describe the patient's relevant medical history and current presentation, including:

a) full details of the patient's mental state, behaviour and treatment for mental disorder;
b) so far as it is within the knowledge of the person writing the report, a statement as to whether, at a time when the patient was mentally disordered, the patient has neglected or harmed themselves or threatened themselves with harm, or has harmed other persons or threatened them with harm, or damaged property or threatened to damage property, together with details of any neglect, harm, damage or threats;
c) an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient were to be discharged from guardianship, and how any such risks could be managed effectively;

d) an assessment of the patient's strengths and any other positive factors of which the tribunal should be aware;
e) whether the patient has a learning disability that may adversely affect their understanding or ability to cope with the tribunal hearing, and whether there are any approaches or adjustments that the panel may consider in order to deal with the case fairly and justly.

iii) Social Circumstances Report

20. This report must be up-to-date and specifically prepared for the use of the tribunal. It must include full details of the following:

a) the patient's home and family circumstances, and the housing facilities available;
b) so far as it is practicable, a summary of the views of the patient's nearest relative, unless (having consulted the patient) the person compiling the report considers that it would be inappropriate to consult the nearest relative;
c) so far as it is practicable, the views of any person who plays a significant part in the care of the patient but is not professionally concerned with that care;
d) the views of the patient, including their concerns, hopes and beliefs;
e) the opportunities for employment available to the patient;
f) what (if any) community support is being, or would be, made available to the patient, and the author's views as to its likely effectiveness were the guardianship order to continue, or were it to be discharged;
g) the patient's financial circumstances (including entitlement to benefits);
h) an assessment of the patient's strengths and any other positive factors of which the tribunal should be aware;
i) an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient were to be discharged by the tribunal, and how any such risks could be managed effectively.

D. CONDITIONALLY DISCHARGED PATIENTS

21. A conditionally discharged patient is a restricted patient who has been discharged from hospital into the community, subject to a condition that the patient will remain liable to be recalled to hospital for further treatment, should it become necessary.

22. In the case of a restricted patient in hospital, the tribunal may make a provisional decision to order a conditional discharge. Before it finally grants a conditional discharge, the tribunal may defer its decision so that arrangements to its satisfaction can be put in place. Unless and until the tribunal finally grants a conditional discharge, the patient remains an in-patient, and so the in-patient part of the practice direction (and not this part) applies.

23. Upon being notified by the tribunal of an application or reference, the responsible clinician must send or deliver a responsible clinician's report, and any social supervisor must send or deliver a social circumstances report. The reports must contain the specified information and must be sent or delivered to the tribunal as soon as practicable, and in any event within 3 weeks after the responsible clinician or social supervisor (as the case may be) received the notification.

24. The responsible clinician and any social supervisor must also, at the same time, send copies of their reports to the Secretary of State.

i) Responsible Clinician's Report

25. This report must be up-to-date and specifically prepared for the use of the tribunal. Unless it is not reasonably practicable, the report must be written or counter-signed by the patient's Responsible Clinician and must describe the patient's relevant medical history and current presentation, including:

a) full details of the patient's mental state, behaviour and treatment for mental disorder;
b) so far as it is within the knowledge of the person writing the report, a statement as to whether, at a time when the patient was mentally disordered, the patient has neglected or harmed themselves or threatened themselves with harm, or has harmed other persons or threatened them with harm, or damaged property or threatened to damage property, together with details of any neglect, harm, damage or threats;
c) an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient were to be absolutely discharged by the tribunal, and how any such risks could be managed effectively;
d) an assessment of the patient's strengths and any other positive factors of which the tribunal should be aware;
e) details of any existing advance decisions to refuse treatment for mental disorder made by the patient;
f) whether the patient has a learning disability that may adversely affect their understanding or ability to cope with the tribunal hearing, and whether there are any approaches or adjustments that the panel may consider in order to deal with the case fairly and justly.
g) If the patient does not have a social supervisor, the responsible clinician must also provide, or arrange to be provided, as much of the social circumstances information below as can reasonably be obtained in the time available.

ii) Social Circumstances Report

26. This report must be up-to-date and specifically prepared for the use of the tribunal. It must include full details of the following:

a) the patient's full name (and any alternative names used in their patient records);
b) the patient's date of birth, age and usual place of residence;
c) the patient's first language and, if it is not English, whether an interpreter is required and, if so, in which language
d) if the patient is deaf, whether the patient will require the services of a British Sign Language interpreter or a Relay Interpreter;
e) the patient's home and family circumstances, and the housing facilities available;
f) so far as it is practicable, the views of any person who plays a significant part in the care of the patient but is not professionally concerned with that care;
g) the views of the patient, including their concerns, hopes and beliefs;
h) the opportunities for employment available to the patient;
i) what (if any) community support or after-care is being, or would be, made available to the patient, and the author's views as to its likely effectiveness were the conditional discharge to continue, or were the patient to be absolutely discharged;
j) the patient's financial circumstances (including entitlement to benefits);

k) an assessment of the patient's strengths and any other positive factors of which the tribunal should be aware;
l) an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient were to be absolutely discharged by the tribunal, and how any such risks could be managed effectively.
m) the name and address of any deputy or attorney appointed for the patient under the Mental Capacity Act 2005;
n) details of any registered lasting or enduring power of attorney made by the patient.

E. PATIENTS UNDER THE AGE OF 18

27. All the above requirements apply, as appropriate, depending upon the type of case.

28. In addition, *for all patients under the age of 18*, the **Social Circumstances Report** must state:

a) the names and addresses of any persons with parental responsibility, and how they acquired parental responsibility;
b) which public bodies either have liaised or need to liaise in relation to after-care services that may be provided under section 117 of the Act;
c) the outcome of any liaison that has taken place;
d) if liaison has not taken place, why not – and when liaison will take place;
e) the details of any multi-agency care plan in place or proposed;
f) whether there are any issues as to funding the care plan and, if so, the date by which it is intended that those issues will be resolved;
g) who will be the patient's care coordinator following discharge;
h) whether the patient's needs have been assessed under the Chronically Sick and Disabled Persons Act 1970 (as amended) and, if not, the reasons why such an assessment has not been carried out and whether it is proposed to carry out such an assessment;
i) if there has been an assessment under the Chronically Sick and Disabled Persons Act 1970, what needs have been identified and how those needs will be met;
j) if the patient is subject to or has been the subject of a care order or an interim care order, the date and duration of any such order, the identity of the relevant local authority, any person(s) with whom the local authority shares parental responsibility, whether the patient is the subject of any care proceedings which have yet to be concluded and, if so, the court in which such proceedings are taking place and the date of the next hearing, whether the patient comes under the Children (Leaving Care) Act 2000, whether there has been any liaison between, on the one hand, social workers responsible for mental health services to children and adolescents and, on the other hand, those responsible for such services to adults, and the name of the social worker within the relevant local authority who is discharging the function of the nearest relative under section 27 of the Act;
k) if the patient is subject to guardianship under section 7 of the Act, whether any orders have been made under the Children Act 1989 in respect of the patient, and what consultation there has been with the guardian;
l) if the patient is a ward of court, when the patient was made a ward of court and what steps have been taken to notify the court that made the order of any significant steps taken, or to be taken, in respect of the patient;

m) whether any orders under the Children Act 1989 are in existence in respect of the patient and, if so, the details of those orders, together with the date on which such orders were made, and whether they are final or interim orders;
n) if a patient has been or is a looked after child under section 20 of the Children Act 1989, when the child became looked after, why the child became looked after, what steps have been taken to discharge the obligations of the local authority under paragraph 17(1) of Schedule 2 of the Children Act 1989, and what steps are being taken (if required) to discharge the obligations of the local authority under paragraph 10 (b) of Schedule 2 of the Children Act 1989;
o) if a patient has been treated by a local authority as a child in need (which includes children who have a mental disorder) under section 17(11) of the Children Act 1989, the period or periods for which they have been so treated, why they were considered to be a child in need, what services were or are being made available to the child by virtue of that status, and details of any assessment of the child;
p) if a patient has been the subject of a secure accommodation order (under section 25 of the Children Act 1989), the date on which the order was made, the reasons it was made, and the date it expired.

LORD JUSTICE CARNWATH
SENIOR PRESIDENT OF TRIBUNALS

06 April 2012