Social circumstances reports for mental health tribunals – Part 2

Christopher Curran, **Malcolm Golightley** and **Phil Fennell** provide advice on drafting a social circumstances report (SCR) for mental health tribunals, which was made a regulatory requirement in England under the Tribunals, Courts and Enforcement Act 2007. Part 1 of this article, which provided advice on the provision of a SCR, was published in June 2010 *Legal Action* 30.

Drafting a SCR

In England, the provision of information in mental health cases by the responsible authority and the Secretary of State for Justice is governed by the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 SI No 2699 r32(5) and a Practice Direction issued by the tribunal in 2008.[1] (In Wales, there is not an absolute duty, but the information provided for the tribunal must, where 'reasonably practicable', include a SCR: Mental Health Review Tribunal for Wales Rules 2008 SI No 2705 r15(5)(c) and Part B para 2 of the Schedule to these rules.)

SCR writers should ensure that they are fully aware of the broad general information about the patient that helps to put the SCR into context, in addition to the regulatory requirements under Section E of the 2008 Practice Direction. If the report writer is unclear about the law, the tribunal's powers, or how best to draft a SCR, it is strongly recommended that s/he liaises closely with a knowledgeable colleague and takes advice from him/her. The Practice Direction states what must be included in the SCR; however, the report writer needs to include additional information in order to provide a comprehensive picture of the patient's current social circumstances. Report writers are advised to be wary of cutting and pasting

SCRs: content and layout

It is a matter of personal preference as to whether the SCR goes further than merely addressing the regulatory requirements. Simply addressing the issues detailed in the 2008 Practice Direction would not provide the tribunal panel (or the patient's representative) with the requisite information. The authors recommend that report writers consider addressing the following when drafting a SCR. Note: **(RR)** refers to a regulatory requirement to provide information under sections E and H of the 2008 Practice Direction.

- **(RR) SCR**: it is a regulatory requirement that: 'The statement provided to the tribunal must *include an up to date* social circumstances report *prepared for the tribunal*' (2008 Practice Direction, para 16, authors' emphasis) (recycling a report originally written for a hospital managers' review should be avoided). If several weeks have elapsed since the first SCR, the report writer should submit an addendum, thus ensuring it is up to date on the day of the hearing. If the SCR relates to a restricted patient (for example, MHA 1983 ss37 and 41) the addendum report should be submitted several days before the hearing so that the secretary of state (ie, via the Mental Health Unit at the Ministry of Justice) may comment.
- **Patient's full name**: is s/he known by any other names?
- **Date of birth/age**.
- **Ward**: community address if under a community treatment order (CTO).
- **Status**: for example, married, single, divorced.
- **MHA status**: for example, ss3, 34, 41.
- **Date of original detention**.
- **Referral or an application date**: indicate if this is a referral or an application to the tribunal.
- **Address at time of admission**: ie, home address if known.
- **SCR writer**: include the full name and title, for example, care co-ordinator, approved mental health professional, community psychiatric nurse, social worker, occupational therapist and place of work (for example, assertive outreach team or community mental health team). Will the SCR writer remain involved with the patient after the hearing date?
- **Professional relationship to patient**: for example, care co-ordinator and length of involvement.
- **Responsible clinician**: name and length of time treating the patient.
- **Care co-ordinator**: full name, title, contact details and date of most recent contact.
- **Responsible authority/primary care trust**: for example, highlight commissioning authority or regional secure commissioning team involvement.
- **Index offence**: if appropriate and whether Multi-Agency Public Protection Arrangements (MAPPA) involved, the sex offenders register, etc.[2]
- **Sources of information**: that form the basis of the SCR, for example, under the refocused Care Programme Approach (CPA) and other meetings, patient's electronic/case records, with relevant dates.[3]
- **Chronology**: provision of previous admission dates in a chronological table is very helpful. Indicate the date the present authority to detain was renewed, periods of MHA 1983 s17 leave or a detailed CTO history.
- **Current admission**: for example, the writer's understanding of events leading to admission, how the patient has responded to the detention and other significant events, for example, s17 leave.
- **Brief psychiatric history**: include the patient's past MHA history (a chronological table is recommended). The success or failure of any previous discharge arrangements should be described – what lessons were learnt?
- **(RR) Home and family circumstances**: this information enables the tribunal to gauge the level of family support or otherwise.
- **(RR) Nearest relative** (where the patient is unrestricted): summarise the nearest relative's views. In order to identify the correct nearest relative, it is useful to list close family members (ie, spouse/partner, children, parents: MHA 1983 s26) and specify dates of birth/age and relationship to the patient.[4] A chronological family table is strongly recommended.
- **(RR) Views of any person with a substantial part in the care of the patient**.
- **Independent mental health advocate**: include any details relating to advocacy input.
- **(RR) Patient's views**: include the patient's concerns, hopes and beliefs in relation to the tribunal proceedings.
- **(RR) Employment opportunities**: The patient's education and employment history should be included. Employment is an important part of daily living and effective aftercare planning should address this issue and also consider available leisure options.
- **(RR) Housing facilities available**: ie, what housing facilities are actually available if the tribunal discharges the patient, for example, location, type of tenancy, etc. Following discharge from hospital under s3, for example, it would not be considered best practice to ask the patient to 'present themselves at a local

extracts from any previous SCR, in case they include outdated information which may mislead the tribunal, or worse, repeat assertions made in previous reports that have no basis in fact.

Support and guidance

Line managers of the professionals responsible for drafting SCRs for tribunals should ensure the individuals are fully aware of the regulatory requirements under the 2008 Practice Direction and that they receive regular Mental Health Act (MHA) 1983 training and ongoing access to specialist legal advice.

Legal representatives

If the SCR does not comply fully with the regulatory requirements of the 2008 Practice Direction and the application is, for example, for discharge from the MHA 1983 s3, the patient's legal representative may feel that there is insufficient information, in respect of the patient's s117 aftercare arrangements, effective discharge planning and long-term support, for the tribunal to reach a decision on the criteria set out within MHA 1983 s72. S/he may wish to take instructions regarding an application to the tribunal for an adjournment in order that detailed consideration may be given to aftercare arrangements, including accommodation, community support, etc, conscious, of course, of the overriding objective (see Part 1 of this article).

Tribunal etiquette

Health and social care professionals attending a hearing are reminded that mental health tribunals are courts of law and a judicial process. Tribunals are not hospital meetings and should not be treated as such. Examples of inappropriate behaviour include late attendance, mobile telephones ringing, attendees chatting, chewing gum or eating/drinking during the hearing. If the patient requires a break, his/her representative should draw this to the attention of the tribunal panel.

Conclusion

While realising that SCR writers are busy professionals, it is important that the SCR considers the information highlighted above and complies fully with all the regulatory requirements. A well-thought-out and structured SCR makes all the difference when a tribunal panel is trying to read and digest complex information in a limited time frame (sometimes having more than one hearing per day). Failure to provide the requisite information presents the tribunal panel with an incomplete picture of the patient's aftercare needs and available community resources. This may lead to an adjournment and, in turn, may not only be stressful for the patient but present an additional and unnecessary charge on the public purse.

homeless centre'.

■ **CPA (New CPA) review (see above) and s117 aftercare plan**: include date and information from most recent CPA and s117 aftercare meetings.

■ **(RR) Community support**: that is, or will be made, available following discharge (if any) and highlight its effectiveness, including details of the contingency and relapse action plan that addresses future needs in the event of a deterioration in the patient's mental health. Has an occupational therapy assessment taken place and is feedback available? Does the patient have any physical health needs requiring additional community support following discharge?

■ **Physical health**: are there any physical health issues that may require consideration when developing the patient's aftercare plan? Is the patient registered with a GP and does s/he have access to an NHS dentist?

■ **Carer's needs assessment**: the Carers (Recognition and Services) Act 1995 provides a right to an assessment if a person provides 'a substantial amount of care on a regular basis' (s1(1)(b)).

■ **(RR) Financial circumstances**: including entitlement, type and amount of any state benefits or other income. Include information about savings and assets; other sources of income; any known debts or pending litigation; arrangements for managing financial affairs, for example, appointeeship, Court of Protection, entitlement to additional benefits following discharge. How the patient copes with handling his/her finances and general day-to-day money management is an important part of his/her aftercare planning. If the patient has a history of putting him/herself at financial risk consider the benefit of completing a 'Debt and Mental Health Evidence Form' (DMHEF).[5] Chris Fitch et al found the '… DMHEF provides a tool which shows potential for standardising communication between health professionals, creditors, money advisers, and people reporting mental health and debt problems …'[6]

■ **(RR) Patient's strengths**: include other positive factors the tribunal should be aware of in coming to a view on whether the patient should be discharged.

■ **(RR) Risk assessment**: consider the extent to which the patient or other persons would be likely to be at risk if the patient is discharged by the tribunal, and clearly state how any such risks could best be managed in the community. Where relevant include a forensic history. If there is an offender history, where possible try and check the information via the Police National Computer or with a colleague in the Probation Service.

■ **Social history**: a social history helps to put any index offence or offender and/or psychiatric history into context, for example, significant events/family history/developmental milestones etc.

■ **Additional needs**: always consider the age of the patient (for example, young or older person), gender, race, ethnicity, culture, class and disability: are there any aspects of the person's individual circumstances requiring additional consideration, for example, use of interpreter, specialist support, equipment, etc?

■ **Safeguarding issues**: regarding the protection of children or vulnerable adults following discharge. For example, what risk management strategies need to be considered before discharge from hospital?

■ **Conclusion and recommendations**: ie, summarise the most important conclusions and the writer's own recommendations.

■ **Layout of the SCR**: it is strongly recommended that the SCR is paginated and includes clear paragraph headings (avoid pages of text without clear headings and sub-headings), paragraph numbers and careful proof reading. Consider the use of appendices if the SCR is especially lengthy. The SCR should always be dated and signed by the report writer.

■ **(RR) Supervised community treatment/CTO**: precise information about the content of a SCR may be found in the 2008 Practice Direction at Section H, paragraphs 25 and 26(a)-(j). If the patient is subject to a CTO the statement provided to the tribunal must include an up to date SCR prepared for the tribunal.[7] The content of the SCR for a CTO varies slightly. In addition to the information which the authors recommend above, a SCR for a CTO is required to address a number of other factors. For example, there is a requirement to provide:

– **(RR) information on the effectiveness of the community support available to the patient**; **or** the likely effectiveness of the community support which would be available to the patient if discharged from supervised community treatment;

– **(RR) an account of the patient's progress while a community patient; and** any

– **(RR) conditions or requirements to which s/he is subject under the CTO; and**

– **(RR) details of any behaviour that has put him/her or others at risk of harm; and**

– **(RR) risk assessment** – an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient remains a community patient (authors' emphasis).

Adjournments may also cause an unnecessary delay in the determination of the patient's appeal against his/her detention or restriction of individual liberty; in such a case they may infringe the positive obligation to provide a speedy review under article 5(4) of the European Convention on Human Rights.

1 See Practice Direction. First-tier Tribunal. Health Education and Social Care Chamber. Mental Health Cases, available at: www.tribunals.gov.uk/Tribunals/Documents/Rules/Mentalhealthcaseshesc.pdf.
2 See: www.noms.justice.gov.uk/protecting-the-public/supervision/mappa/.
3 See *Refocusing the Care Programme Approach: policy and positive practice guidance, 2008:* ' ... this guidance updates policy and sets out positive practice guidance for trusts and commissioners to review local practice to refocus CPA within mental health services'. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647.
4 David Hewitt, *The nearest relative handbook*, 2nd edition, Jessica Kingsley Publishers, 2009, £17.99. This useful text provides helpful guidance in the law related to the nearest relative.
5 Available at: www.rcpsych.ac.uk/mentalhealthinfo/debtmentalhealthcontents/toolsforworkers.aspx. See also Neasa MacEarlean, 'The high cost of debt to your wellbeing', *Independent*, 5 December 2009.
6 Chris Fitch, Robert Chaplin and Simon Tulloch, 'The Debt and Mental Health Evidence Form. A tool for health professionals and lenders dealing with customers with self-reported mental health problems', *The Psychiatrist*, (2010) 34, pp95–100.
7 Christopher Curran, Dr Tony Zigmond and Catherine Grimshaw, 'Brief Guide to Community Treatment Orders under the Mental Health Act 1983', *Openmind*, No 162, March/April 2010, pp26–27.

Christopher Curran is a Visiting Fellow at the School of Health and Social Care, University of Lincoln, a mental health tribunal member and a former Mental Health Act Commissioner. Malcolm Golightley is Professor of Social Work and Head of the School of Health and Social Care, University of Lincoln. He is a former Mental Health Act Commissioner. Phil Fennell is Professor of Law at Cardiff Law School, University of Cardiff and a former Mental Health Act Commissioner. The authors would like to thank John Horne, a Teaching Fellow at Northumbria Law School and a mental health tribunal judge; Bill Leason, a partner at Hempsons Solicitors and a mental health tribunal judge; Catherine Grimshaw, solicitor; and *Openmind*. The views expressed in this article are those of the authors alone and do not necessarily reflect those of an employer or statutory body.

Mental health law update – Part 2

Robert Robinson and **Michael Konstam** report on recent developments in mental health law. This article looks at important relevant case-law, as will the final part of this update, which will be published in August 2010 *Legal Action*. Part 1 of this article, which discussed the latest policy and legislation in mental health law, appeared in June 2010 *Legal Action* 29. Readers are invited to submit summaries of significant unreported cases.

CASE-LAW

Application to the First-tier Tribunal: effect of patient being placed on a community treatment order

The patient in **AA v Cheshire and Wirral Partnership NHS Foundation Trust** [2009] UKUT 195 (AAC), 1 October 2009, had applied to the First-tier Tribunal while detained under Mental Health Act (MHA) 1983 s3. Before the application was heard, the patient had been placed on a community treatment order (CTO). The Regional Tribunal Judge decided that the effect of the patient's change of status was that the First-tier Tribunal ceased to have jurisdiction to deal with the application. So, the proceedings were deemed to have lapsed.

On appeal to the Upper Tribunal, it was held that the Regional Tribunal Judge had been wrong and that, in these circumstances, the application continues and is to be decided as if it were an application for discharge from the CTO.

The Upper Tribunal drew attention to the need for the parties to co-operate in such cases: 'In particular, it will clearly be incumbent on any representative of the applicant to inform the tribunal as soon as possible whether or not the application is being withdrawn and it is also clearly incumbent on all parties to inform the tribunal whether or not a postponement of any hearing that has already been fixed will be required in the light of the change of circumstances' (para 61).

Comment: A patient who applied to the tribunal with the object of being discharged from detention may have no wish to continue the application following the making of a CTO. Such an applicant should be reminded of his/her right to withdraw the application. Withdrawal in these circumstances preserves the right to apply to the tribunal within the first six months of the CTO (and at intervals thereafter). Likewise, the CTO patient's right to apply to the tribunal is not affected if the application is heard after the order has been made and the CTO is upheld.

The role of the representative appointed by the tribunal

Another point which arose in *AA* (above) was the role of a representative appointed by the First-tier Tribunal to represent a patient. Rule 11(7) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules ('the First-tier Tribunal Rules') 2008 SI No 2699 reads:

> *... In a mental health case, if the patient has not appointed a representative, the tribunal may appoint a legal representative for the patient where –*
>
> *(a) the patient has stated that they do not wish to conduct their own case or that they wish to be represented; or*
>
> *(b) the patient lacks the capacity to appoint a representative but the tribunal believes that it is in the patient's best interests for the patient to be represented.*

The Upper Tribunal's starting point was that a representative appointed under this rule must act on the client's valid instructions. Where, however, the client lacks capacity to give valid instructions, the representative's duty is different. First, the representative should try to ascertain the client's wishes so far as these are relevant. The representative must inform the tribunal of any such wishes. Second, the representative must 'exercise his or her judgment and advance any argument that he or she considers to be in the patient's "best interests", which ... will not necessarily involve arguing for the patient's discharge' (para 18).

Even where the client does have capacity