HM Courts & Tribunals Service

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Reports for Mental Health Tribunals

Message from the Deputy Chamber President

Mental Health Tribunals are both an integral part of the mental health system and an integral part of the English judicial system. And the judges and panel members who decide the cases that come before them cannot do their job properly without the help of all the doctors, clinicians, nurses and social workers who are providing front-line treatment, care and support for patients, both in hospitals and in the community.

Writing reports and preparing evidence for Mental Health Tribunals is a key responsibility for all professionals although, with so many competing demands on professional time, it can be quite a burden to sit down and pull together all the necessary information. That is why I want to thank report-writers, and the Mental Health Act Administrators who are central to this process, for putting in all the commitment and effort that is needed to ensure that Mental Health Tribunals have all the up-to-date evidence, facts and material that they need to do justice.

Many people forget that proceedings before Mental Health Tribunals are judicial, just like proceedings before courts, although our judges do all they can to keep things informal and accessible. Consequently, for those whose task it is to prepare statements and reports, and to do so on time, the duty to ensure that all the key details are included is absolutely fundamental.

It is in no-one's interest if cases have to be adjourned because reports are late or lack the crucial facts or the up-to-date information required, and we know that patients and their families find it very distressing and frustrating if tribunals cannot make a decision because someone has failed in their legal duty to provide all the evidence that tribunals are entitled to. Its also very unfair on those people who do provide good quality reports on time because, if a case gets adjourned, these reports may become out-of-date and updates then have to be called for.

To try and help, the Senior President of Tribunals has issued a Practice Direction, which has the full force of law and is legally binding. It spells out the minimum requirements and time limits for various types of report. Compliance is compulsory and not optional. Indeed, when reports are late or fall short of these minimum requirements — with bad consequences for patients, families, carers, doctors, nurses and other professionals — the tribunal has legal power to order remedies, sanctions and costs. But we hope that, by providing clear guidance, we can avoid such measures.

As a judicial tribunal, our role is to assess and balance all the relevant evidence, facts and opinions before us, in order to make our contribution to the difficult and important task of protecting and helping vulnerable people, their families and the community.

This is the second edition of this booklet, and it takes account of changes to the practice direction that came into effect on 6th April 2012. There are three key changes:

a. In all cases involving a community patient whose case is referred to the tribunal, Responsible Clinicians are asked to give us their assessment of the patients capacity to decide whether or not to attend, or be represented at, a hearing of reference. We very much hope that Clinicians will cooperate with this, as the intention is to save patients and others (including Clinicians, Hospitals and Social Work staff) from having to personally attend unnecessary hearings, where the case can be justly and fairly decided on the papers;
b. In cases involving patients on a conditional discharge, there is a new requirement that Responsible Clinicians and Social Supervisors send their reports directly to the tribunal;
c. Where the patient is under the age of 18, there are new requirements in relation to the Social Circumstances report.

In order to properly understand and balance all the relevant issues and information, we need the best evidence that we can get. I hope that this guidance, based on the Practice Direction, will be of help to everyone who, in the course of a busy day, has to sit down and prepare evidence for Mental Health Tribunals.

Judge Mark Hinchliffe

Your questions answered

Who has the duty to ensure that compliant reports are prepared, written and submitted on time?

The Responsible Authority has this duty, except in cases involving patients on a conditional discharge, where the Responsible Clinician and any Social Supervisor have this duty.

Who is the Responsible Authority?

In relation to a patient detained in a hospital under the Mental Health Act 1983 (as amended), this usually means the responsible Primary Care Trust, Strategic Health Authority, Local Health Board, Special Health Authority, NHS Trust or Foundation Trust or, in relation to a registered establishment, the person or persons registered in respect of the establishment.

In relation to a community patient (unless responsibility has been assigned elsewhere) the Responsible Authority will usually be the Trust, Authority or Board for the hospital where the patient was liable to be detained immediately before the Community Treatment Order was made.

In relation to a patient subject to guardianship, the Responsible Authority will be the responsible local authority social services department.

What must the Responsible Authority (or as appropriate, the Responsible Clinician and any Social Supervisor) do?

The relevant Responsible Authority must always accurately identify itself by correctly stating the full name of the Trust, Authority or Board on all covering correspondence. It should also quote the tribunal's case number, the patient's name and date of birth, the relevant hospital, the section of the Mental Health Act involved, and the date it received the patient's application or reference. The Responsible Authority must then:

a. ensure that a statement is prepared that contains or has attached all the information, and reports required (see below); and

b. include in the statement, or subsequently make available, certain specified documents, if directed to do so by the tribunal.

The statement, reports and documentation must be sent on time to the tribunal.

In the case of a restricted patient other than a conditionally discharged patient, the relevant Responsible Authority must also send a copy of the documents and reports to the Secretary of State.

How should the statement, reports and documents be sent?

The statement, reports and documents must be sent safely and securely. These days, most statements and reports will be written on computers, so there should be an electronic version available (e.g. a Word document or PDF). The tribunal prefers and encourages the Responsible Authority to submit the statement and reports by secure email such as nhs.net or cjsm. If secure email is not possible or practicable, documents should be sent by first class recorded delivery post.

The tribunal's email address for submitting statements and reports is: TSMHnorthreportsteam@hmcts.gsi.gov.uk or TSMHSouthreportsteam@hmcts.gsi.gov.uk.

Please see Annex 1 for guidance.

Ministry of Justice (Mental Health Casework Section) email address is: MHUTribunalCorrespondence@noms.gsi.gov.uk.

Why should the Responsible Authority (or as appropriate, the Responsible Clinician and any Social Supervisor) comply, and what happens if reports do not comply, or are late?

Rule 2(4) provides that parties must help the tribunal to deal with the case fairly and justly, and must co-operate with the tribunal generally. Rule 16(1)(b) extends the duty to answer questions or produce documents to any person asked by the tribunal to assist. The law also says that the tribunal may give directions as to the issues on which it requires evidence or submissions, the nature of the evidence or submissions it requires, and whether expert evidence is to be permitted.

If anyone fails to comply with a direction, summons or order, the tribunal may take such action as it considers just, which may include:

a. requiring the failure to be remedied;
b. excluding evidence that would otherwise be admissible;
c. refusing to adjourn;
d. refusing to consent to the withdrawal of an application (Rule 17(2));
e. adjourning the case and, if appropriate, making an order for wasted costs against a representative;
f. by order, requiring any defaulting party or any other person to answer questions in writing;
g. by order, requiring any defaulting party or any other person to produce any specified document or report;
h. by summons, requiring any defaulting party or any other person to attend personally as a witness before the tribunal;
i. referring the matter to the Upper Tribunal with a request that it exercise its power under section 25 of the Tribunals, Courts and Enforcement Act 2007.

What are the time limits?

The relevant Responsible Authority must send the statement and reports as soon as possible and, at the very latest, so that they are received by the tribunal and, where appropriate, the Ministry of Justice (Mental Health Casework Section) within three weeks of the Responsible Authority first receiving the patient's application or reference.

What extra documents should be provided?

In addition to the obligation on the relevant Responsible Authority to provide the statement and reports specified in the Senior President's Practice Direction (see below), the tribunal has power under The Tribunals Procedure (First-tier Tribunal) (Health, Education & Social Care Chamber) Rules 2008 to require any person to provide documents, information or submissions which relate to any issue in the proceedings.

Consequently, if the tribunal so directs, copies of the following documents must be included in the statement provided to the tribunal if they are within the possession of the Responsible Authority (otherwise they must be made available to the tribunal if requested at any other time by the tribunal):

a. the application, order or direction that constitutes the original authority for the patient's detention or guardianship under the Mental Health Act, together with all supporting recommendations, reports and records made in relation to it under the Mental Health (Hospital, Guardianship and Treatment) Regulations 2008;
b. a copy of every tribunal decision, and the reasons given, since the application, order or direction being reviewed was made or accepted; and
c. where the patient is liable to be detained for treatment under section 3 of the Mental Health Act, a copy of any application for admission for assessment that was in force immediately prior to the making of the section 3 application.

Can the tribunal prohibit disclosure to a patient of information, statements, reports or documents?

Rule 14 of The Tribunals Procedure (First-tier Tribunal) (Health, Education & Social Care Chamber) Rules 2008 provides that the tribunal may give a direction prohibiting the disclosure to a patient (or any other person) of information, statements, reports or documents if:

a. the tribunal is satisfied that such disclosure would be likely to cause that person or some other person serious harm; and
b. the tribunal is satisfied, having regard to the interests of justice, that it is proportionate to give such a direction.

If the relevant Responsible Authority, or the source or author of the information, statement, report or document considers that the tribunal should give a direction prohibiting the disclosure of the material to the patient, they must:

a. separate and exclude the relevant information, statement, report or document from any other material submitted;
b. separately provide to the tribunal copies of the excluded information, statement, report or document, ensuring that the excluded material is clearly marked:

'NOT TO BE DISCLOSED TO THE PATIENT WITHOUT THE EXPRESS PERMISSION OF THE TRIBUNAL'

c. provide the tribunal with full written reasons for the proposed exclusion, so that the tribunal may decide for itself whether the grounds for exclusion have been made out and whether the information, statement, report or document should be disclosed to the patient, or whether it should be excluded.

If it makes an exclusion direction then the tribunal and all other persons, including parties, witnesses and representatives, must conduct themselves and the proceedings as appropriate in order to give effect to the exclusion.

If the tribunal gives a direction that prevents disclosure to a patient who has an appointed representative, then the tribunal may give a direction that the information, statement, report or document may nevertheless be disclosed to that representative. But the tribunal will only do this if it is satisfied that:

a. disclosure to the representative would be in the interests of the party; and

b. the representative will act in accordance with the exclusion direction.

Excluded information, statements, reports or documents that are disclosed to a representative must not be disclosed either directly or indirectly to any other person without the tribunal's consent.

In any event, unless the tribunal gives a direction to the contrary, information about mental health cases and the names of any persons concerned in such cases must not be made public.

What must the statement and reports contain?

It depends on the type of case. This guidance considers five types of case:

A. In-patients;

B. Guardianship Patients;

C. Community Patients;

D. Conditionally Discharged Patients;

E. Patients under the age of 18.

A. In-patients

A patient is an in-patient if at the time of the application or referral they are receiving in-patient treatment in hospital for mental disorder, even if it is being given informally or under an application, order or direction other than that to which the tribunal application or reference relates. This includes patients detained for assessment or treatment under sections 2 or 3 of the Mental Health Act.

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 (section 37) or Direction - whether or not the patient is also a Restricted Patient (section 41) or subject to a Restriction or Limitation Direction.

In the case of a Restricted Patient detained in hospital, a tribunal may be thinking about discharging a patient subject to a condition that the patient will remain liable to be recalled to hospital for further treatment, should it become necessary. Before it finally grants a Conditional Discharge, the tribunal may defer its decision so that proper arrangements to its satisfaction can be put in place. Until the tribunal finally grants a Conditional Discharge, the patient remains an in-patient, and so this 'in-patient' part of the guidance applies.

If the patient is detained in hospital as an in-patient, then the Responsible Authority must send the tribunal a statement that contains or has attached:

1. Statement of Information about the Patient
2. Responsible Clinician's Report
3. In-patient Nursing Report (a copy of the patients current nursing plan must be appended to the report).
4. Social Circumstances Report

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 is 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.

Where a patient is detained under Section 2 of the Act - the Responsible Authority must prepare the required documents as soon as practicable after the 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 at least one hour ahead of the hearing.

1. Statement of information about the patient

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 his 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 constitutes the original authority for the detention of the patient, including the Act of Parliament and the section of that Act by reference to which detention was authorised and details of any subsequent renewal of or change in the authority for detention;

f. details as applicable of the hospital at which the patient is detained;

g. details of any transfers between hospitals under section 19 or section 123 of the Mental Health Act 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. where relevant, the name and address of the local social services authority and NHS body which would have the duty under section 117 of the Mental Health Act to provide after-care services for the patient, were the patient to leave hospital;

j. the name of the patient's Responsible Clinician and the period which the patient has spent under the care of that clinician;

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, and whether the patient has requested that this person is not consulted or kept informed about their 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 it;

n. the name and address of any deputy or attorney appointed under the Mental Capacity Act 2005;

o. details of any registered lasting power of attorney made by the patient that confers authority to make decisions about the patient, and the donee(s) appointed;

p. details of any existing advance decisions to refuse treatment for mental disorder made by the patient.

2. Clinician's report

This report must be up-to-date and specifically prepared for the tribunal. Unless it is not reasonably practicable, the report should 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 ever neglected or harmed themselves, or has ever harmed other persons or threatened them with harm, together with details of any neglect, harm or threats of harm;

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 best be managed;

d. an assessment of the patient's strengths and any other positive factors that the tribunal should be aware of in deciding whether the patient should be discharged.

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.

3. In-patient nursing report

This report must be up-to-date and specifically prepared for the tribunal. In relation to the patient's current in-patient episode it should 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 being granted leave of absence;

e. any incidents where the patient has harmed themselves or others, or has threatened other persons with violence.

f. A copy of the patient's current nursing plan must be appended to the report.

4. Social circumstances report

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

a. the patient's home and family circumstances, and 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 thinks it would be inappropriate to consult the nearest relative;

c. so far as it is practicable, the views of any person who plays a substantial 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 in relation to the tribunal proceedings and their outcome;

e. the opportunities for employment available to the patient;

f. what (if any) community support or after care is, or will be made available to the patient and its effectiveness, if the patient were 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 that the tribunal should be aware of in coming to a view on whether the patient should be discharged;

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 best be managed.

B. Guardianship patients

A patient who has attained the age of 16 years may be received into Guardianship under section 7 or section 37 of the Mental Health Act if it is necessary in the interests of the welfare of the patient or for the protection of others. The Guardian is usually the local authority social services department.

If the patient is a Guardianship Patient, then 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 three weeks after the Responsible Authority made the reference or received a copy of the application or reference:

1. Statement of Information about the Patient
2. Responsible Clinician's Report
3. Social Circumstances Report

1. Statement of Information about the Patient

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 his 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. details of the place where the patient is living;

g. the name and address of the local social services authority and NHS body having a duty under section 117 of the Mental Health Act to provide after-care services for the patient;

h. the name of the patient's Responsible Clinician and the period which the patient has spent under the care of that clinician;

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, and whether the patient has requested that this person is not consulted or kept informed about their care or treatment and if so, the details 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 it;

l. where the patient is subject to the guardianship of a private guardian, the name and address of that guardian;

m. the name and address of any deputy or attorney appointed under the Mental Capacity Act 2005;

n. details of any registered lasting or enduring power of attorney made by the patient, and the donee(s) appointed;

o. details of any existing advance decisions to refuse treatment for mental disorder made by the patient.

2. Responsible Clinician's Report

This report must be up-to-date and specifically prepared for the tribunal. Unless it is not reasonably practicable, the report should 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. in 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 ever neglected or harmed themselves, or has ever harmed other persons or threatened them with harm, or damaged property or threatened to damage property, at a time when the patient was mentally disordered, together with details of any neglect, harm or threats of harm;

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 best be managed;

d. an assessment of the patient's strengths and any other positive factors that the tribunal should be aware of in coming to a view on whether the patient should be discharged.

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.

3. Social Circumstances Report

This report must be up-to-date and specifically prepared for the tribunal. It should 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 thinks it would be inappropriate to consult the Nearest Relative;

c. so far as it is practicable, the views of any person who plays a substantial part in the care of the patient but is not professionally concerned with it;

d. the views of the patient, including their concerns, hopes and beliefs in relation to the tribunal proceedings and their outcome;

e. the opportunities for employment available to the patient;

f. what (if any) community support is or will 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 that the tribunal should be aware of in coming to a view on whether the patient should be discharged;

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 best be managed.

C. Community Patients

A Community Patient is a patient who has previously been detained in hospital for treatment but who has been discharged from hospital on a Community Treatment Order. The patient is subject to a condition that they will remain liable to be recalled to hospital for further treatment, should it become necessary.

If the patient is a Community Patient, under Section 17a of the Act, then 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:

1. Statement of Information about the Patient
2. Responsible Clinician's Report
3. Social Circumstances Report

1. Statement of Information about the Patient

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 his 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 any Care Co-ordinator appointed for the patient;

g. the name and address of any deputy or attorney appointed under the Mental Capacity Act 2005;

h. details of any registered lasting power of attorney made by the patient, and the donee(s) appointed;

i. details of any existing advance decisions to refuse treatment for mental disorder made by the patient.

j. the name of the patient's Responsible Clinician and the date when the patient came under the care of that clinician;

k. 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;

l. the name and address of the patient's nearest relative or of the person exercising that function, and whether the patient has requested that this person is not to be consulted or kept informed about their 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.

2. Responsible Clinician's Report

This report must be up-to-date and specifically prepared for the tribunal. Unless it is not reasonably practicable, the report should 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. detail 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 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. in 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 ever neglected or harmed themselves, or has ever harmed other persons or threatened them with harm, or damaged property or threatened to damage property, together with details of any neglect, harm or threats of harm;

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 best be managed;

g. an assessment of the patient's strengths and any other positive factors that the tribunal should be aware of in coming to a view on whether the patient should be discharged;

i. the reasons why the patient can be treated as a Community Patient without continued detention in hospital, and why it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) of the Mental Health Act to recall the patient to hospital;

h. details of any specific conditions in force regarding the patient under section 17B of the Mental Health Act.

3. Social circumstances report

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

a. the patient's home and family circumstances, and the housing facilities available;

b. in 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 thinks it would be 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 it;

d. the views of the patient, including their concerns, hopes and beliefs in relation to the tribunal;

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 it's likely effectiveness were the community treatment order to continue, or were it to be discharged;

g. details of the patient's financial circumstances (including entitlement to benefits);

h. an assessment of the patient's strengths and any other positive factors that the tribunal should be aware of in coming to a view on whether the patient should be discharged;

i. an account of the patient's progress while a Community Patient, and any conditions or requirements to which the patient is subject under the Community Treatment Order, and details of any behaviour that has put them or others at risk of harm;

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.

D. Conditionally Discharged Patients

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.

There are cases where a tribunal may be thinking about granting a Conditional Discharge but, before it finally grants a Conditional Discharge, the tribunal may *defer* its decision so that proper arrangements can be put in place. Until the tribunal finally grants a Conditional Discharge, the patient remains an in-patient, and so the in-patient part of the guidance (and *not* this part) applies.

Upon being notified by the tribunal of an application or reference, the Responsible Clinician must send or deliver a Responsible Clinicians report, and any Social Supervisor must send or deliver a Social Circumstances report. The reports must contain the specified information and must be delivered to the tribunal as soon as is practicable, and in any event within 3 weeks after the Responsible Clinician or Social Supervisor (as the case may be) received the notification.

The Responsible Clinician and any Social Supervisor must also, at the same time, send copies of their reports to the Secretary of State.

1. Statement of Information about the Patient

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 his 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 name and address of any deputy or attorney appointed under the Mental Capacity Act 2005;

f. details of any registered lasting power of attorney made by the patient, and the donee(s) appointed;

g. details of any existing advance decisions to refuse treatment for mental disorder made by the patient.

2. Responsible Clinician's Report

This report must be up-to-date and specifically prepared for the tribunal. Unless it is not reasonably practicable, the report should 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. in 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 ever neglected or harmed themselves, or has ever harmed other persons or threatened them with harm, or damaged property or threatened to damage property, together with details of any neglect, harm or threats of harm;

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 best be managed;

d. an assessment of the patient's strengths and any other positive factors that the tribunal should be aware of in coming to a view on whether the patient should be discharged.

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 understand or ability to cope with a 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.

3. Social Circumstances Report

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

a. the patient's full name full name (and any alternative names used in their patient records)

b. the patient's date of birth, age and usual place residence;

c. the patient's first language and, if it 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 substantial part in the care of the patient but is not professionally concerned with it;

g. the views of the patient, including their concerns, hopes and beliefs in relation to the tribunal proceedings and their outcome;

h. the opportunities for employment available to the patient;

i. what (if any) community support is or will be made available to the patient and the author's views as to it's 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 that the tribunal should be aware of in coming to a view on whether the patient should be absolutely discharged;

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 best be managed.

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, and the donee(s) appointed.

E. Patients under the age of 18

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

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.

Annex 1

TSMH Reports Team

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Cambridgshire
Cheshire
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Herefordshire
Hertfordshire
Lancashire
Leicestershire and Rutland
Lincolnshire
Mersyside
Norfolk
North Yorkshire
Northamptonshire
Northumberland
Nottinghamshire
Shropshire
South Yorkshire
Staffordshire
Tyne and Wear
Warwickshire
West Midlands
West Yorkshire
Worcestershire

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Kent
Oxfordshire
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Surrey
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Wiltshire