Tribunals Service

Mental Health

Reports for Mental Health Tribunals

www.tribunals.gov.uk

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on those people who do provide good quality reports on time because, if a case gets adjourned, these reports may become out-of-date and updates then have to be called for.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.

To do this, and 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.

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 DO?

The 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 and, in the case of a restricted patient other than a conditionally discharged patient, to the Ministry of Justice (Mental Health Casework Section).

HOW SHOULD THE STATEMENT, REPORTS & 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. WORD or pdf). The tribunal prefers and encourages the Responsible Authority to submit the statement and reports by secure email. The nhs.net system is secure. 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 & reports is: TSMHnorthreportsteam@tribunals.gsi.gov.uk or TSMHSouthreportsteam@tribunals.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 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. 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, 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;

f. by summons, requiring any person to attend before the tribunal;

g. by summons, requiring any person to produce any specified document or report;

h. 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 Responsible Authority must send the statement and reports as soon as it can 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 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 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 & 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 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, 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, however, 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 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 a statement that contains or has attached:

1. Statement of Information about the Patient
2. Clinician's Report
3. In-Patient Nursing Report
4. 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 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 under section 19 or section 123 of the Mental Health Act since the 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;

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's personal welfare, and the donee(s) appointed;

p. details of any registered lasting or enduring power of attorney made by the patient that confers authority to make decisions about the patient's property and affairs, and the donee(s) appointed;

q. 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, 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 the patient has ever neglected or harmed themselves, or has ever harmed other persons or threatened them with harm, 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 deciding whether the patient should be discharged.

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;

b. if the patient is under the age of 18, the names and addresses of any individuals with parental responsibility, and how they acquired parental responsibility;

c. 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;

d. 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;

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

f. the opportunities for employment and the housing facilities available to the patient;

g. what (if any) community support is or will be made available to the patient and its effectiveness, if the patient were to be discharged from hospital;

h. the patient's financial circumstances (including entitlement to benefits);

i. 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;

j. 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 a statement that contains or has attached:

1. Statement of Information about the Patient
2. 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;

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 power of attorney made by the patient that confers authority to make decisions about their personal welfare, and the donee(s) appointed;

o. details of any registered lasting or enduring power of attorney made by the patient that confers authority to make decisions about their property and affairs, 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, 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 the patient has ever neglected or harmed themselves, or has ever harmed other persons or threatened them with harm, 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.

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;

b. if the patient is under the age of 18, the names and addresses of any individuals with parental responsibility, and how they acquired parental responsibility;

c. 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;

d. 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;

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

f. the opportunities for employment and the housing facilities available to the patient;

g. what (if any) community support is or will be made available to the patient and its effectiveness;

h. the patient's financial circumstances (including entitlement to benefits);

i. 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;

j. 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, then the Responsible Authority must send a statement that contains or has attached:

1. Statement of Information about the Patient
2. 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 that confers authority to make decisions about their personal welfare, and the donee(s) appointed;

i. details of any registered lasting or enduring power of attorney made by the patient that confers authority to make decisions about their property and affairs, and the donee(s) appointed;

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

2. CLINICIANS 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, including:

a. details of the original authority for the patient's supervised community treatment under the Mental Health Act;

b. the name of the patient's responsible clinician and the length of time the patient has been under their care;

c. full details of the patient's mental state, behaviour and treatment for mental disorder, and relevant medical history;

d. in so far as it is within the knowledge of the person writing the report, a statement as to whether the patient has ever

neglected or harmed themselves, or has ever harmed other persons or threatened them with harm, at a time when the patient was mentally disordered, together with details of any neglect, harm or threats of harm;

e. 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;

f. 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;

g. 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;

b. if the patient is under the age of 18, the names and addresses of any individuals with parental responsibility, and how they acquired parental responsibility;

c. 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 inappropriate to consult the nearest relative;

d. the views of any person who plays a significant part in the care of the patient but is not professionally concerned with it;

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

f. the opportunities for employment, or for occupation and the housing facilities available to the patient;

g. 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;

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

i. 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;

j. 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;

k. 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.

If the patient has already been granted a Conditional Discharge, then the Responsible Authority must send a statement that contains or has attached:

1. Statement of Information about the Patient
2. 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 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 that confers authority to make decisions about their personal welfare, and the donee(s) appointed;

g. details of any registered lasting or enduring power of attorney made by the patient that confers authority to make decisions about their property and affairs, and the donee(s) appointed;

h. 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, 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 the patient has ever neglected or harmed themselves, or has ever harmed other persons or threatened them with harm, 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 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.

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;

b. if the patient is under the age of 18, the names and addresses of any individuals with parental responsibility, and how they acquired parental responsibility;

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 and the housing facilities available to the patient;

f. what (if any) community support is or will be made available to the patient and its effectiveness;

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 absolutely 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 absolutely discharged by the tribunal, and how any such risks could best be managed.

E. PATIENTS UNDER THE AGE OF 18

All the above requirements apply, as appropriate, depending on the type of case. Additionally, this guidance requires extra information in relation to patients under the age of 18.

1. Arrangements in cases involving patients under the age of 18;
2. Capacity & Competence;
3. Co-ordination between relevant public bodies;
4. Attendance at Tribunals;
5. Assessment of Needs;
6. Children subject to a Care Order;
7. Young People under s.7 Guardianship;
8. Wards of Court;
9. Other Children Act Orders;
10. Looked-after Children;
11. Children in Need;
12. Secure Accommodation.

1. ARRANGEMENTS IN CASES INVOLVING PATIENTS UNDER THE AGE OF 18.

The tribunal makes special provision for children and young people under the age of 18, and has its own Children and Adolescent Mental Health Services (CAMHS) panel of judges and members with particular experience of cases involving under-18s. The desirability of making special arrangements for young people is reflected in 131A of the Mental Health Act. Thus, if the patient is under the age of 18, the Responsible Authority must ensure that the environment in the hospital is suitable to the patient's age – and in deciding how to fulfill the duty, the hospital managers must consult suitable people who have knowledge or experience of cases involving patients who have not attained the age of 18. Additionally, Chapter 36 of the Code of Practice for the Mental Health Act 1983 makes special provision for children and young people.

Because cases involving young people under the age of 18 impose specific requirements on Responsible Authorities, hospitals, clinicians, nurses, social workers and carers, the tribunal needs specific evidence to be included in the reports provided to it – particularly the Social Circumstances report. For example, if the patient is under the age of 18, this report must state the names and addresses of any individuals with parental responsibility, and explain how they acquired parental responsibility. Additionally the tribunal aims to ensure that all those who have responsibility for the young patient take the trouble to share their information and opinions prior to a tribunal.

2. CAPACITY & COMPETENCE

The Mental Capacity Act 2005 provides that a person over 16 years of age lacks capacity in relation to a matter if, at the material time, they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It is irrelevant whether the impairment or disturbance is permanent or temporary, and a lack of capacity cannot be established merely by reference to a person's age or appearance, or a condition, or an aspect of behaviour, which might lead others to make unjustified assumptions about capacity.

In the case of Gillick v West Norfolk and Wisbech Area Health Authority [1986] A.C.112 the court held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the competence to consent to that intervention. This is described as being "Gillick Competent".

If capacity (by reference to the Mental Capacity Act), or competence (by reference to the Gillick case) are issues in a case, the *Clinician's* report should state:

a. whether it is considered that the patient lacks capacity and the reasons for so considering;

b. whether it is considered that the patient is or is not Gillick Competent.

3. CO-ORDINATION BETWEEN RELEVANT PUBLIC BODIES

Although the duty under section 117 of the Mental Health Act does not arise until the time when a patient is discharged, a tribunal considering discharging a patient under the age of 18 from hospital will expect to be provided with some basic information on what after-care arrangements might be made under section 117. Consequently, Responsible Authorities and social services departments should begin identifying appropriate after-care services for all young patients before the first hearing of a tribunal case.

This also means that discussion of after-care needs, involving liaison and coordination between local social services departments and other relevant agencies, should take place well in advance of the hearing. The level of coordination required will of course vary from case to case, but the information to be provided as set out below should help to ensure that the minimum level of liaison necessary to achieve a fair and just determination of tribunal proceedings is achieved. The Social Circumstances report should, therefore, state:

a. which public bodies either have liaised or need to liase;

b. if liaison has not taken place, why not – and when liaison will take place;

c. the outcome of any liaison that has taken place;

d. the details of any multi-agency care plan in place or proposed;

e. 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;

f. who will be the patient's care coordinator following discharge.

4. ATTENDANCE AT TRIBUNALS

Where there is a need for liaison between different organisations, or different teams within the same organisation, it is expected that the authors of the reports provided for the tribunal *will attend in person* at the tribunal.

5. ASSESSMENT OF NEEDS

The Chronically Sick & Disabled Persons Act 1970 (as amended) applies to children who have a mental disorder and imposes duties on local social services departments in relation to the assessment of needs, welfare and housing. Amongst other things the local social services department must:

a. Assess and identify 'disabled' children (which includes children who have a mental disorder) in its area and provide information about services;

b. Maintain a register of 'disabled' children;

c. Provide services for 'disabled' children that minimise the effect of their disabilities and gives them the opportunity to lead lives as normal as possible;

d. Provide for 'disabled' children living with their families the following:

- Advice, guidance and counselling;
- Occupational, social, cultural or recreational activities;
- Home help;
- Facilities for or assistance with travel to and from home, to take advantage of local services.

The *Social Circumstances* report should therefore state:

a. whether the young patient's needs have been assessed;

b. if not, the reasons why such an assessment has not been carried out and whether it is proposed to carry out an assessment;

c. if there has been an assessment, details of the needs that have been identified and how it is proposed to meet those needs.

6. CHILDREN SUBJECT TO A CARE ORDER

If the patient is subject to or has been the subject of a Care Order or an Interim Care Order (pursuant to either s.31 or s.38 of the Children Act 1989), the *Social Circumstances* report should state:

a. the date and duration of any such order ;

b. the identity of the relevant local authority;

c. any person(s) with whom the local authority shares parental responsibility;

d. 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;

e. whether the patient comes under the Children (Leaving Care) Act 2000;

f. if the patient is nearing his or her 16th birthday or is older, whether there has been any liaison between CAMHS and Adult Social Services;

g. the name of the social worker within the relevant local authority who is discharging the function of the Nearest Relative pursuant to s.27 Mental Health Act.

7. CHILDREN UNDER S.7 GUARDIANSHIP

If the patient is subject to Guardianship under s.7 of the Mental Health Act, the Social Circumstances report should state:

a. whether any orders have been made under the Children Act in respect of the patient and, if so, of what nature, and when;

b. what consultation there has been with the guardian.

8. WARDS OF COURT

If the patient is a Ward of Court, the *Social Circumstances* report should state:

a. when the patient was made a Ward of Court;

b. what steps have been taken to notify the Court that made the Wardship Order of any significant steps either taken or to be taken in respect of the patient.

9. OTHER CHILDREN ACT ORDERS

If there are any orders in existence in respect of the patient, then details should be contained in the *Social Circumstances* report together with the date on which such orders were made, and whether they are final or interim orders. Such orders may include one or more of the following:

- Residence Orders;
- Prohibited Steps Orders;
- Specific Issues Orders;
- Contact Orders;
- Special Guardianship Orders;
- Supervision Orders.

10. LOOKED AFTER CHILDREN

If a patient has been or is a 'looked after' child by virtue of s.20 of the Children Act, the *Social Circumstances* report should state:

a. when the child became looked after;

b. why the child became looked after;

c. what steps have been taken to discharge the obligations of the local authority pursuant to Paragraph 17(1) of Schedule 2 of the Children Act (the appointment of a visitor if no parent is visiting the patient regularly);

d. what steps are being taken (if required) to discharge the obligations of the local authority pursuant to Paragraph 10 (b) of Schedule 2 of the Children Act.

11. CHILDREN IN NEED

If a patient has been treated by a local authority as a child 'in need' (which includes children who have a mental disorder) pursuant to s.17 (11) of the Children Act, the *Social Circumstances* report should state:

a. when he or she was so treated;

b. why he or she was considered to be a child in need;

c. what services were or are being made available to the patient by virtue of that status;

d. details of any assessment of the child.

12. SECURE ACCOMODATION

If a patient has been the subject of a Secure Accommodation Order (pursuant to s.25 of the Children Act), the *Social Circumstances* report should state:

a. when the order was made;

b. when it expired;

c. the reasons why such an order was required.

Annex 1
TSMH Reports Team

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Cambridgeshire
Cheshire
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Greater Manchester
Herefordshire
Hertfordshire
Lancashire
Leicestershire and Rutland
Lincolnshire
Merseyside
Norfolk
North Yorkshire
Northamptonshire
Northumberland
Nottinghamshire
Shropshire
South Yorkshire
Staffordshire
Tyne and Wear
Warwickshire
West Midlands
West Yorkshire
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Surrey
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Wiltshire