



Tribunals Judiciary

PRACTICE DIRECTION HEALTH EDUCATION AND SOCIAL CARE CHAMBER MENTAL HEALTH CASES

1. This Practice Direction applies to a “mental health case” as defined in Rule 1(3) the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (“the 2008 Rules”).
2. For the purposes of this Practice Direction, a patient is an “in-patient” if at the time of the application or referral he is 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.

CONTENTS OF STATEMENTS FROM THE RESPONSIBLE AUTHORITY AND SECRETARY OF STATE

3. The responsible authority must send a statement to the Tribunal and, in the case of a restricted patient other than a conditionally discharged patient, to the Secretary of State, so that it is received by the Tribunal as soon as is practicable and in any event within three weeks after the responsible authority received a copy of the application or reference..
4. If the patient is a conditionally discharged patient, the Secretary of State must send or deliver a statement to the Tribunal so that it is received by the Tribunal as soon as practicable, and in any event within 6 weeks after the Secretary of State received a copy of the application or a request from the Tribunal.
5. If the patient is neither a conditionally discharged patient, nor a community patient subject to supervised community treatment, nor a patient subject (or to be subject) to after-care under supervision, the statement to the Tribunal must contain the information, documents and reports specified in paragraphs 8(a) to (e) below.
6. If the patient is a conditionally discharged patient, the statement to the Tribunal must, where possible, contain the reports specified in paragraphs 8(c) and (d) below.
7. If the patient is a community patient subject to supervised community treatment the statement to the Tribunal must contain the reports specified in paragraphs 8(f) below.
8. The information, documents and reports referred to above are:
 - a. the information about the patient set out at Section B below;
 - b. the documents concerning the patient set out at Section C below;
 - c. the clinician's report set out at Section D below;
 - d. the social circumstances report set out at Section E below;
 - e. if the patient is an in-patient, the nursing report set out at Section F below;
 - f. the reports set out in Section H below.

9. Where the patient is a restricted patient, the Secretary of State must send to the Tribunal as soon as practicable and in any event within 3 weeks after the Secretary of State received the responsible authority's statement (within 2 weeks in proceedings under section 75(1) of the Mental Health Act 1983), a statement containing the information set out at Section G below.
10. If the patient is subject (or to be subject) to after-care under supervision, the statement must include the information, documents and reports specified in the Annex to this Practice Direction.

SECTION B. INFORMATION ABOUT THE PATIENT

11. The statement provided to the Tribunal must, in so far as it is within the knowledge of the responsible authority, include the following 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, or of the reception of the patient into guardianship, together with details of the application, order or direction that constitutes the original authority for the detention or guardianship 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 or liable to be detained, or the place where the patient is living if received into guardianship;
 - g. details of any transfers under section 19 or section 123 of the Mental Health Act 1983 since the application, order or direction was made;
 - h. where the patient is detained or liable to be 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 having the duty under section 117 of the Mental Health Act 1983 to provide after-care services for the patient (or which would have it 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. where the patient is subject to the guardianship of a private guardian, the name and address of that guardian;

- o. the name and address of any deputy or attorney appointed under the Mental Capacity Act 2005;
- p. details of any registered lasting power of attorney made by the patient that confers authority to make decisions about his personal welfare, and the donee(s) appointed by him;
- q. details of any registered lasting or enduring power of attorney made by the patient that confers authority to make decisions about his property and affairs, and the donee(s) appointed by him; and
- r. details of any existing advance decisions to refuse treatment for mental disorder made by the patient.

SECTION C. DOCUMENTS CONCERNING THE PATIENT

12. 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 1983, 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 1983, a copy of any application for admission for assessment that was in force immediately prior to the making of the section 3 application.

SECTION D. CLINICIAN'S REPORT

13. The statement provided to the Tribunal must include an up-to-date clinical report prepared for the Tribunal.
14. Unless it is not reasonably practicable, the report must be written or counter-signed by the patient's responsible clinician;
15. This report must describe the patient's relevant medical history, to include:
- 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 himself, or has ever harmed other persons or threatened them with harm, at a time when he 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 is 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 he should be discharged; and
 - e. if appropriate, the reasons why the patient might be treated in the community without continued detention in hospital, but should remain

subject to recall on supervised community treatment.

SECTION E. SOCIAL CIRCUMSTANCES REPORT

16. The statement provided to the Tribunal must, include an up-to-date social circumstances report prepared for the Tribunal.

17. This report must include the following information:

- a. the patient's home and family circumstances;
- b. in 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. in 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 his 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, if the patient is discharged from hospital;
- g. the patient's financial circumstances (including his 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 he should be discharged; and
- i. an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient is discharged by the Tribunal, and how any such risks could best be managed.

SECTION F. IN-PATIENT NURSING REPORT

18. This report must include in relation to the patient's current in-patient episode, 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 he has failed to return when required, after being granted leave of absence; and
- e. any incidents where the patient has harmed himself or others, or has threatened other persons with violence.

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

SECTION G. THE SECRETARY OF STATE'S STATEMENT (RESTRICTED PATIENTS ONLY)

20. In cases involving a restricted patient, the Secretary of State must provide a statement to the Tribunal containing any written comments he wishes to make upon the statement he has received from the responsible authority, together

with any further information relevant to the application as may be available to him.

21. In addition, the Secretary of State must provide to the Tribunal the following further information:
 - a. a summary of the offence or alleged offence that resulted in the patient being detained in hospital subject to a restriction order or, in the case of a patient subject to a restriction or limitation direction, that resulted in him being remanded in custody, kept in custody or sentenced to imprisonment;
 - b. a record of any other criminal convictions or findings recorded against the patient;
 - c. full details of the history of the patient's liability to detention under the Mental Health Act 1983 since the restrictions were imposed.

SECTION H. PATIENTS RECEIVING SUPERVISED COMMUNITY TREATMENT (SCT)

Clinical Reports

22. The statement provided to the Tribunal must include an up-to-date clinical report prepared for the Tribunal.
23. Unless it is not reasonably practicable to do so, the report must be written or counter-signed by the patient's responsible clinician.
24. This report must include:
 - a. details of the original authority for the patient's supervised community treatment under the Mental Health Act 1983;
 - 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 himself, or has ever harmed other persons or threatened them with harm, at a time when he 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 is 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 he 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 1983 to recall the patient to hospital; and
 - h. details of any specific conditions in force regarding the patient under section 17B of the Mental Health Act 1983.

Social Circumstances Report

25. The statement provided to the Tribunal must include an up-to-date social

circumstances report prepared for the Tribunal.

26. This report must include the following information:
- a. the patient's home and family circumstances;
 - 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 his concerns, hopes and beliefs in relation to the Tribunal;
 - e. the opportunities for employment, or for occupation and the housing facilities available to the patient;
 - f. 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;
 - g. details of the patient's financial circumstances (including his 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 he should be discharged;
 - i. an account of the patient's progress while a community patient, and any conditions or requirements to which he is subject under the community treatment order, and details of any behaviour that has put him or others at risk of harm; and
 - j. an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient remains a community patient.
27. This Practice Direction is made by the Senior President of tribunals with the agreement of the Lord Chancellor. It is made in the exercise of powers conferred by the Tribunals, Courts and Enforcement Act 2007.

ANNEXE

PATIENTS WHO ARE, OR WILL BE, SUBJECT TO AFTER-CARE UNDER SUPERVISION

28. The statement provided to the Tribunal must include;
- a. the details of the after-care services being (or to be) provided under section 117 of the Mental Health Act 1983;
 - b. details of any requirements imposed (or to be imposed) on the patient under section 25D of the Mental Health Act 1983;
 - c. the information about the patient specified in Section I below;
 - d. the documents concerning the patient specified in Section J below;
 - e. the reports specified in Section K below.

SECTION I. INFORMATION ABOUT THE PATIENT

29. The statement provided to the Tribunal must include, in so far as it is within the knowledge of the responsible authority, the following information;
- a. the patient's full name, date of birth, age and address;
 - b. the date of the acceptance of the supervision application in respect of the patient;

- c. details of the after-care services provided (or to be provided) under section 117 of the Mental Health Act 1983,
- d. details of any requirements imposed (or to be imposed) under section 25D(1) of the Mental Health Act 1983,
- e. any reclassification of the form of mental disorder from which the patient is recorded as suffering in the supervision application reported in accordance with section 25F(1) of the Mental Health Act 1983;
- f. the name and address of the person who is (or is to be) the patient's responsible clinician and the period (if any) during which he has been in charge of the patient's medical treatment;
- g. the name and address of the person who is (or is to be) the patient's supervisor;
- h. where a registered medical practitioner other than the patient's responsible clinician is or has recently been largely concerned in the treatment of the patient, details of the name and address of that practitioner and the period which the patient has spent under his care;
- i. the name and address of any place where the patient (if he has been discharged) is receiving medical treatment;
- j. the name and address of the hospital where the patient was detained or liable to be detained when the supervision application was made;
- k. the dates of any previous tribunal hearings in relation to the patient since he became subject to after-care under supervision, the decisions reached at such hearings and the reasons given;
- l. details of any proceedings in the Court of Protection and of any receivership order made in respect of the patient;
- m. the name and address of the patient's nearest relative or of any other person who is exercising that function;
- n. the name and address of any other person who takes a close interest in the patient.

SECTION J. DOCUMENTS CONCERNING THE PATIENT

30. Copies of the following documents must be made available to the Tribunal if they are within the possession of the responsible authority;
- a. the original supervision application;
 - b. any report furnished under section 25G(3)(b) of the Mental Health Act 1983 in relation to renewal of the supervision application;
 - c. any record of modification of the after-care services provided.

SECTION K. REPORTS

Clinical report

31. The statement provided to the Tribunal must include an up-to-date clinician report prepared for the Tribunal.
32. Unless it is not reasonable practicable, the report must be written or counter-signed by the patients responsible clinician.
33. This report must describe the patient's relevant medical history and contain a full report on the patient's mental condition.

Supervisor's Report

34. Where the patient is subject to after-care under supervision the statement provided to the Tribunal must include an up-to-date report prepared for the Tribunal by the patient's supervisor,
35. This report must include the following information:
- a. the patient's home and family circumstances, including the attitude of the patient's nearest relative or the person so acting and the attitude of any person who plays a substantial part in the care of the patient but is not professionally concerned with any of the after-care services provided to the patient;
 - b. his progress in the community whilst subject to after-care under supervision including an assessment of the effectiveness of that supervision.

Social Circumstances Report

36. Where the patient has not yet left hospital the statement provided to the Tribunal must include an up-to-date social circumstances report prepared for the Tribunal.
37. This report must include the following information:
- a. the patient's home and family circumstances, including the attitude of the patient's nearest relative or the person so acting;
 - b. the opportunities for employment or occupation and the housing facilities which would be available to the patient upon his discharge from hospital;
 - c. the availability of community support and relevant medical facilities;
 - d. the financial circumstances of the patient.