PRACTICE DIRECTION

FIRST-TIER TRIBUNAL

HEALTH EDUCATION AND SOCIAL CARE CHAMBER

STATEMENTS AND REPORTS IN MENTAL HEALTH CASES

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1. This Practice Direction is made by the Senior President of Tribunals with the agreement of the Lord Chancellor in the exercise of powers conferred by Section 23 of the Tribunals, Courts and Enforcement Act 2007. It applies to a "mental health case" as defined in Rule 1(3) the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008. Rule 32 requires that certain statements and reports must be sent or delivered to the tribunal (and, in restricted cases, to the Secretary of State) by the Responsible Authority, the Responsible Clinician and any Social Supervisor (as the case may be). This Practice Direction specifies the contents of such documents. It replaces the previous Practice Directions on mental health cases dated 30 October 2008 and 6 April 2012, with effect from 28 October 2013.

2. In this Practice Direction "the Act" refers to the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

3. This Practice Direction contains five separate parts for the following categories of patient:

   A. IN-PATIENTS (NON-RESTRICTED AND RESTRICTED)
   B. COMMUNITY PATIENTS
   C. GUARDIANSHIP PATIENTS
   D. CONDITIONALLY DISCHARGED PATIENTS
   E. PATIENTS UNDER THE AGE OF 18.

4. Responsible Authorities and authors of reports should refer to the relevant part of this Practice Direction, depending on the status of the patient under the Act.

SIR JEREMY SULLIVAN
SENIOR PRESIDENT OF TRIBUNALS

28 October 2013

A. IN-PATIENTS (NON-RESTRICTED AND RESTRICTED)

5. For the purposes of this Practice Direction, a patient is an in-patient if they are detained in hospital to be assessed or treated for a mental disorder, whether admitted through civil or criminal justice processes, including a restricted patient (i.e. subject to special restrictions under the Act), and including a patient transferred to hospital from custody. A patient is to be regarded as an in-patient detained in a hospital even if they have been permitted leave of absence, or have gone absent without leave.

6. In the case of a restricted patient detained in hospital, the tribunal may make a provisional decision to order a Conditional Discharge. However, before it finally decides to grant a Conditional Discharge, the tribunal may defer its decision so that satisfactory arrangements can be made. The patient will remain an in-patient unless and until the tribunal finally grants a Conditional Discharge, so this part of the Practice Direction applies.

7. If the patient is an in-patient, the Responsible Authority must send or deliver to the tribunal the following documents containing the specified information in accordance with the relevant paragraphs below:

- *Statement of Information about the Patient.*
- *Responsible Clinician's Report, including any relevant forensic history.*
- *Nursing Report, with the patient's current nursing plan attached.*
- *Social Circumstances Report including details of any Care Pathway Approach (CPA) and/or Section 117 aftercare plan in full or in embryo and, where appropriate, the additional information required for patients under the age of 18, and any input from a Multi Agency Public Protection Arrangements (MAPPA) agency or meeting.*

8. In all in-patient cases, except where a patient is detained under Section 2 of the Act, the Responsible Authority must send to the tribunal the required documents containing the specified information, so that they are received by the tribunal as soon as practicable and in any event within 3 weeks after the Authority made or received the application or reference. If the patient is a restricted patient, the Authority must also, at the same time, send copies of the documents to the Secretary of State (Ministry of Justice).

9. Where a patient is detained under Section 2 of the Act, the Responsible Authority must prepare the required documents as soon as practicable after receipt of a copy of the application or a request from the tribunal. If specified information has to be omitted because it is not available, then this should be mentioned in the statement or report. These documents must be made available to the tribunal panel and the patient's representative at least one hour before the hearing is due to start.

10. The authors of reports should have personally met and be familiar with the patient. If an existing report becomes out-of-date, or if the status or the circumstances of the patient change after the reports have been written but before the tribunal hearing takes place (e.g. if a patient is discharged, or is recalled), the author of the report should then send to the tribunal an addendum addressing the up-to-date situation and, where necessary, the new applicable statutory criteria.

Statement of Information about the Patient – In-Patients

11. The statement provided to the tribunal must be up-to-date, specifically prepared for the tribunal, signed and dated, and must include:

a) the patient's full name, date of birth, and usual place of residence;
b) the full official name of the Responsible Authority;
c) the patient's first language/dialect and, if it is not English, whether an interpreter is required and, if so, in which language/dialect;
d) if the patient is deaf, whether the patient will require the services of British Sign Language Interpreters and/or a Relay Interpreter;
e) a chronological table listing:
   - the dates of any previous admissions to, discharge from, or recall to hospital, stating whether the admissions were compulsory or voluntary;
   - the date when the current period of detention in hospital originally commenced, stating the nature of the application, order or direction that is the authority for the detention of the patient;
   - the dates of any subsequent renewal of, or change in, the authority for the patient's detention, and any changes in the patient's status under the Act;
   - dates and details of any hospital transfers since the patient's original detention;
   - the date of admission or transfer to the hospital where the patient now is;
   - the dates and outcomes of any tribunal hearings over the last three years;
f) the name of the patient's Responsible Clinician and the date when the patient came under the care of that clinician;
g) the name and contact details of the patient's Care Co-ordinator, Community Psychiatric Nurse, Social Worker/AMHP or Social Supervisor;
h) where the patient is detained in an independent hospital, details of any NHS body that funds, or will fund, the placement;
i) the name and address of the local social services authority which, were the patient to leave hospital, would have a duty to provide Section 117 after-care services;
j) the name and address of the NHS body which, were the patient to leave hospital, would have a duty to provide Section 117 after-care services;
k) the name and address of any legal representative acting for the patient;
l) except in the case of a restricted patient, the name and address of the patient's Nearest Relative or of the person exercising that function, whether the patient has made any request that their Nearest Relative should not be consulted or should not be kept informed about the patient's care or treatment and, if so, the details of any such request, whether the Responsible Authority believes that the patient has capacity to make such a request and the reasons for that belief;
m) the name and address of any other person who plays a significant part in the care of the patient but who is not professionally involved;
n) details of any legal proceedings or other arrangements relating to the patient's mental capacity, or their ability to make decisions or handle their own affairs.

Responsible Clinician's Report – In-Patients

12. The report must be up-to-date, specifically prepared for the tribunal and have numbered paragraphs and pages. It should be signed and dated. The report should be written or counter-signed by the patient's Responsible Clinician. The sources of information for the events and incidents described must be made clear. This report should not be an addendum to (or reproduce extensive details from) previous reports, or recite medical records, but must briefly describe the patient's recent relevant medical history and current mental health presentation, and must include:

a) whether there are any factors that may affect the patient's understanding or ability to cope with a hearing and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;
b) details of any index offence(s) and other relevant forensic history;
c) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital;
d) reasons for any previous admission or recall to hospital;
e) the circumstances leading up to the patient's current admission to hospital;
f) whether the patient is now suffering from a mental disorder and, if so, whether a diagnosis has been made, what the diagnosis is, and why;
g) whether the patient has a learning disability and, if so, whether that disability is associated with abnormally aggressive or seriously irresponsible conduct;
h) depending upon the statutory criteria, whether any mental disorder present is of a nature or degree to warrant, or make appropriate, liability to be detained in a hospital for assessment and/or medical treatment;
i) details of any appropriate and available medical treatment prescribed, provided, offered or planned for the patient's mental disorder;
j) the strengths or positive factors relating to the patient;
k) a summary of the patient's current progress, behaviour, capacity and insight;
l) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication or comply with any appropriate medical treatment for mental disorder that is or might be made available;
m) in the case of an eligible compliant patient who lacks capacity to agree or object to their detention or treatment, whether or not deprivation of liberty under the Mental Capacity Act 2005 (as amended) would be appropriate and less restrictive;
n) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;
o) whether (in Section 2 cases) detention in hospital, or (in all other cases) the provision of medical treatment in hospital, is justified or necessary in the interests of the patient's health or safety, or for the protection of others;
p) whether the patient, if discharged from hospital, would be likely to act in a manner dangerous to themselves or others;
q) whether, and if so how, any risks could be managed effectively in the community, including the use of any lawful conditions or recall powers;
r) any recommendations to the tribunal, with reasons.

Nursing Report – In-Patients

13. The report must be up-to-date, specifically prepared for the tribunal and have numbered paragraphs and pages. It should be signed and dated. The sources of information for the events and incidents described must be made clear. This report should not recite the details of medical records, or be an addendum to (or reproduce extensive details from) previous reports, although the patient's current nursing plan should be attached. In relation to the patient's current in-patient episode, the report must briefly describe the patient's current mental health presentation, and must include:

a) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;
b) the nature of nursing care and medication currently being made available;
c) the level of observation to which the patient is currently subject;
d) whether the patient has contact with relatives, friends or other patients, the nature of the interaction, and what community support the patient has;
e) strengths or positive factors relating to the patient;
f) a summary of the patient's current progress, engagement with nursing staff, behaviour, cooperation, activities, self-care and insight;
g) 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 as and when required, after having been granted leave;
h) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication or treatment for mental disorder that is or might be made available;
i) details of any incidents in hospital where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;
j) any occasions on which the patient has been secluded or restrained, including the reasons why such seclusion or restraint was necessary;
k) whether (in Section 2 cases) detention in hospital, or (in all other cases) the provision of medical treatment in hospital, is justified or necessary in the interests of the patient's health or safety, or for the protection of others;
l) whether the patient, if discharged from hospital, would be likely to act in a manner dangerous to themselves or others;
m) whether, and if so how, any risks could be managed effectively in the community, including the use of any lawful conditions or recall powers;
n) any recommendations to the tribunal, with reasons.

Social Circumstances Report – In-Patients

14. The report must be up-to-date, specifically prepared for the tribunal and have numbered paragraphs and pages. It should be signed and dated. The sources of information for the events and incidents described must be made clear. This report should not be an addendum to (or reproduce extensive details from) previous reports, but must briefly describe the patient's recent relevant history and current presentation, and must include:

a) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;
b) details of any index offence(s) and other relevant forensic history;
c) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital;
d) the patient's home and family circumstances;
e) the housing or accommodation available to the patient if discharged;
f) the patient's financial position (including benefit entitlements);
g) any available opportunities for employment;
h) the patient's previous response to community support or Section 117 aftercare;
i) so far as is known, details of the care pathway and Section 117 after-care to be made available to the patient, together with details of the proposed care plan;
j) the likely adequacy and effectiveness of the proposed care plan;
k) whether there are any issues as to funding the proposed care plan and, if so, the date by which those issues will be resolved;
l) the strengths or positive factors relating to the patient;
m) a summary of the patient's current progress, behaviour, compliance and insight;
n) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;
o) the patient's views, wishes, beliefs, opinions, hopes and concerns;
p) except in restricted cases, the views of the patient's Nearest Relative unless (having consulted the patient) it would inappropriate or impractical to consult the Nearest Relative, in which case give reasons for this view and describe any attempts to rectify matters;
q) the views of any other person who takes a lead role in the care and support of the patient but who is not professionally involved;
r) whether the patient is known to any MAPPA meeting or agency and, if so, in which area, for what reason, and at what level - together with the name of the Chair of any MAPPA meeting concerned with the patient, and the name of the representative of the lead agency;
s) in the event that a MAPPA meeting or agency wishes to put forward evidence of its views in relation to the level and management of risk, a summary of those views (or an Executive Summary may be attached to the report); and where relevant, a copy of the Police National Computer record of previous convictions should be attached;
t) in the case of an eligible compliant patient who lacks capacity to agree or object to their detention or treatment, whether or not deprivation of liberty under the Mental Capacity Act 2005 (as amended) would be appropriate and less restrictive;
u) whether (in Section 2 cases) detention in hospital, or (in all other cases) the provision of medical treatment in hospital, is justified or necessary in the interests of the patient's health or safety, or for the protection of others;
v) whether the patient, if discharged from hospital, would be likely to act in a manner dangerous to themselves or others;
w) whether, and if so how, any risks could be managed effectively in the community, including the use of any lawful conditions or recall powers;
x) any recommendations to the tribunal, with reasons.

B. COMMUNITY PATIENTS

15. The Responsible Authority must send 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 Authority made or received the application or reference:

    - *Statement of Information about the Patient*

    - *Responsible Clinician's Report, including any relevant forensic history.*

    - *Social Circumstances Report including details of any Section 117 aftercare plan and, where appropriate, the additional information required for patients under the age of 18, and any input from a Multi Agency Public Protection Arrangements (MAPPA) agency or meeting.*

16. The authors of reports should have personally met and be familiar with the patient. If an existing report becomes out-of-date, or if the status or the circumstances of the patient change after the reports have been written but before the tribunal hearing takes place (e.g. if a patient is recalled, or again discharged into the community), the author of the report should then send to the tribunal an addendum addressing the up-to-date situation and, where necessary, the new applicable statutory criteria.

Statement of Information about the Patient – Community Patients

17. The statement provided to the tribunal should be up-to-date, signed and dated, specifically prepared for the tribunal, and must include:

a) the patient's full name, date of birth, and current place of residence;
b) the full official name of the Responsible Authority;
c) the patient's first language/dialect and, if it is not English, whether an interpreter is required and, if so, in which language/dialect;
d) if the patient is deaf, whether the patient will require the services of British Sign Language Interpreters and/or a Relay Interpreter;
e) a chronological table listing:
   - the dates of any previous admissions to, discharge from, or recall to hospital, stating whether the admissions were compulsory or voluntary, and including any previous instances of discharge on to a Community Treatment Order (CTO);
   - the date of the underlying order or direction for detention in hospital prior to the patient's discharge onto the current CTO;
   - the date of the current CTO;
   - the dates of any subsequent renewal of, or change in, the authority for the patient's CTO, and any changes in the patient's status under the Act;
   - the dates and outcomes of any tribunal hearings over the last three years;
f) the name of the patient's Responsible Clinician and the date when the patient came under the care of that clinician;
g) the name and contact details of the patient's Care Co-ordinator, Community Psychiatric Nurse, and/or Social Worker/AMHP;
h) the name and address of the local social services authority which has the duty to provide Section 117 after-care services;
i) the name and address of the NHS body which has the duty to provide Section 117 after-care services;
j) the name and address of any legal representative acting for the patient;
k) the name and address of the patient's Nearest Relative or of the person exercising that function, whether the patient has made any request that their Nearest Relative should not be consulted or should not be kept informed about the patient's care or treatment and, if so, the details of any such request, whether the Responsible Authority believes that the patient has capacity to make such a request and the reasons for that belief;
l) the name and address of any other person who plays a significant part in the care of the patient but who is not professionally involved;
m) details of any legal proceedings or other arrangements relating to the patient's mental capacity, or their ability to make decisions or handle their own affairs.

Responsible Clinician's Report – Community Patients

18. The report must be up-to-date, specifically prepared for the tribunal and have numbered paragraphs and pages. It should be signed and dated. This report should be written or counter-signed by the patient's Responsible Clinician. The sources of information for the events and incidents described must be made clear. The report should not be an addendum to (or reproduce extensive details from) previous reports, or recite medical records, but must briefly describe the patient's recent relevant medical history and current mental health presentation, and must include:

a) where the patient is aged 18 or over and the case is a reference to the tribunal, whether the patient has capacity to decide whether or not to attend or be represented at a tribunal hearing;
b) whether, if there is a hearing, there are any factors that may affect the patient's understanding or ability to cope with it, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;
c) details of any index offence(s) and other relevant forensic history;
d) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital;
e) reasons for any previous admission or recall to hospital;
f) the circumstances leading up to the patient's most recent admission to hospital;
g) the circumstances leading up to the patient's discharge onto a CTO;
h) any conditions to which the patient is subject under Section 17B, and details of the patient's compliance;
i) whether the patient is now suffering from a mental disorder and, if so, what the diagnosis is and why;
j) whether the patient has a learning disability and, if so, whether that disability is associated with abnormally aggressive or seriously irresponsible conduct;
k) whether the patient has a mental disorder of a nature or degree such as to make it appropriate for the patient to receive medical treatment;
l) details of any appropriate and available medical treatment prescribed, provided, offered or planned for the patient's mental disorder;
m) the strengths or positive factors relating to the patient;
n) a summary of the patient's current progress, behaviour, capacity and insight;
o) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication or comply with any appropriate medical treatment for mental disorder that is or might be made available;
p) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;
s) whether it is necessary for the patient's health or safety, or for the protection of others, that the patient should receive medical treatment and, if so, why;
t) whether the patient, if discharged from the CTO, would be likely to act in a manner dangerous to themselves or others;
u) whether, and if so how, any risks could be managed effectively in the community;
v) whether it continues to be necessary that the Responsible Clinician should be able to exercise the power of recall and, if so, why;
w) any recommendations to the tribunal, with reasons.

Social Circumstances Report – Community Patients

19. The report must be up-to-date, specifically prepared for the tribunal and have numbered paragraphs and pages. It should be signed and dated. The sources of information for the events and incidents described must be made clear. This report should not be an addendum to (or reproduce extensive details from) previous reports, but must briefly describe the patient's recent relevant history and current presentation, and must include:

a) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;
b) details of any index offence(s), and other relevant forensic history;
c) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital;
d) the patient's home and family circumstances;
e) the housing or accommodation currently available to the patient;
f) the patient's financial position (including benefit entitlements);
g) any employment or available opportunities for employment;
h) any conditions to which the patient is subject under Section 17B, and details of the patient's compliance;
i) the patient's previous response to community support or Section 117 aftercare;
j) details of the community support or Section 117 after-care that is being, or could be made available to the patient, together with details of the current care plan;
k) whether there are any issues as to funding the current or future care plan and, if so, the date by which those issues will be resolved;
l) the current adequacy and effectiveness of the care plan;
m) the strengths or positive factors relating to the patient;
n) a summary of the patient's current progress, behaviour, compliance and insight;
o) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;
p) the patient's views, wishes, beliefs, opinions, hopes and concerns;
q) the views of the patient's Nearest Relative unless (having consulted the patient) it would inappropriate or impractical to consult the Nearest Relative, in which case give reasons for this view and describe any attempts to rectify matters;
r) the views of any other person who takes a lead role in the care and support of the patient but who is not professionally involved;
s) whether the patient is known to any Multi Agency Public Protection Arrangements (MAPPA) meeting or agency and, if so, in which area, for what reason, and at what level - together with the name of the Chair of any MAPPA meeting concerned with the patient, and the name of the representative of the lead agency;
t) in the event that a MAPPA meeting or agency wishes to put forward evidence of its views in relation to the level and management of risk, a summary of those views (or an Executive Summary may be attached to the report); and where relevant, a copy of the Police National Computer record of previous convictions should be attached;
u) whether it is necessary for the patient's health or safety, or for the protection of others, that the patient should receive medical treatment and, if so, why;
v) whether the patient, if discharged from the CTO, would be likely to act in a manner dangerous to themselves or others;
w) whether, and if so how, any risks could be managed effectively in the community;
x) whether it continues to be necessary that the Responsible Clinician should be able to exercise the power of recall and, if so, why;
y) any recommendations to the tribunal, with reasons.

C. GUARDIANSHIP PATIENTS

20. If the patient has been received into guardianship the Responsible Authority must send to the tribunal the following documents, containing the specified information, so that they are received by the tribunal as soon as practicable and in any event within 3 weeks after the Authority made or received a copy of the application or reference:

    - *Statement of Information about the Patient*

    - *Responsible Clinician's Report, including any relevant forensic history.*

    - *Social Circumstances Report including details of any Care Pathway Approach (CPA) and, where appropriate, the additional information required for patients under the age of 18, and any input from a Multi Agency Public Protection Arrangements (MAPPA) agency or meeting.*

21. The authors of reports should have personally met and be familiar with the patient. If an existing report becomes out-of-date, or if the status or the circumstances of the patient change after the reports have been written but before the tribunal hearing takes place, the author of the report should then send to the tribunal an addendum addressing the up-to-date situation and, where necessary, the new applicable statutory criteria.

Statement of Information about the Patient – Guardianship Patients

22. The statement provided to the tribunal should be up-to-date, signed and dated, specifically prepared for the tribunal, and must include:

a) the patient's full name, date of birth, and current place of residence;
b) the full official name of the Responsible Authority;
c) the patient's first language/dialect and, if it is not English, whether an interpreter is required and, if so, in which language/dialect;
d) if the patient is deaf, whether the patient will require the services of British Sign Language Interpreters and/or a Relay Interpreter;
e) a chronological table listing:
   - the dates of any previous admissions to, discharge from or recall to hospital, stating whether the admissions were compulsory or voluntary;
   - the dates of any previous instances of reception into guardianship;
   - the date of reception into current guardianship, stating the nature of the application, order or direction that constitutes the original authority for the guardianship of the patient;
   - the dates and outcomes of any tribunal hearings over the last three years;
f) the name and address of any private guardian;
g) the name of the patient's Responsible Clinician and the date when the patient came under the care of that clinician;
h) the name and contact details of the patient's Care Co-ordinator, Community Psychiatric Nurse, and/or Social Worker/AMHP;
i) the name and address of any legal representative acting for the patient;
j) the name and address of the patient's Nearest Relative or of the person exercising that function, whether the patient has made any request that their Nearest Relative should not be consulted or should not be kept informed about the patient's care or treatment and, if so, the details of any such request, whether the Responsible Authority believes that the patient has capacity to make such a request and the reasons for that belief;
k) the name and address of any other person who plays a significant part in the care of the patient but who is not professionally involved;
l) details of any legal proceedings or other arrangements relating to the patient's mental capacity, or their ability to make decisions or handle their own affairs.

Responsible Clinician's Report – Guardianship patients

23. The report must be up-to-date, specifically prepared for the tribunal and have numbered paragraphs and pages. It should be signed and dated. The report should be written or counter-signed by the patient's Responsible Clinician. The sources of information for the events and incidents described must be made clear. This report should not be an addendum to (or reproduce extensive details from) previous reports, or recite medical records, but must briefly describe the patient's recent relevant medical history and current mental health presentation, and must include:

a) whether there are any factors that may affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;
b) details of any index offence(s), and other relevant forensic history;
c) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital, and any previous instances of reception into guardianship;
d) the circumstances leading up to the patient's reception into guardianship;
e) any requirements to which the patient is subject under Section 8(1), and details of the patient's compliance,
f) whether the patient is now suffering from a mental disorder and, if so, what the diagnosis is and why;
g) whether the patient has a learning disability and, if so, whether that disability is associated with abnormally aggressive or seriously irresponsible conduct;
h) details of any appropriate and available medical treatment prescribed, provided offered or planned for the patient's mental disorder;
i) the strengths or positive factors relating to the patient;
j) a summary of the patient's current progress, behaviour, capacity and insight;
k) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication or comply with any appropriate medical treatment for mental disorder that is, or might be, made available;
l) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;
m) whether, and if so how, any risks could be managed effectively in the community;
n) whether it is necessary for the welfare of the patient, or for the protection of others, that the patient should remain under guardianship and, if so, why;
o) any recommendations to the tribunal, with reasons.

Social Circumstances Report – Guardianship Patients

24. The report must be up-to-date, specifically prepared for the tribunal and have numbered paragraphs and pages. It should be signed and dated. The sources of information for the events and incidents described should be made clear. This report should not be an addendum to (or reproduce extensive details from) previous reports, but must briefly describe the patient's recent relevant history and current presentation, and must include:

a) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;
b) details of any index offence(s), and other relevant forensic history;
c) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital, and any previous instances of reception into guardianship;
d) the patient's home and family circumstances;
e) the housing or accommodation currently available to the patient;
f) the patient's financial position (including benefit entitlements);
g) any employment or available opportunities for employment;
h) any requirements to which the patient is subject under Section 8(1), and details of the patient's compliance,
i) the patient's previous response to community support;
j) details of the community support that is being, or could be, made available to the patient, together with details of the current care plan;
k) the current adequacy and effectiveness of the care plan;
l) whether there are any issues as to funding the current or future care plan and, if so, the date by which those issues will be resolved;
m) the strengths or positive factors relating to the patient;
n) a summary of the patient's current progress, behaviour, compliance and insight;
o) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;
p) the patient's views, wishes, beliefs, opinions, hopes and concerns;
q) the views of the guardian;
r) the views of the patient's Nearest Relative unless (having consulted the patient) it would inappropriate or impractical to consult the Nearest Relative, in which case give reasons for this view and describe any attempts to rectify matters;
s) the views of any other person who takes a lead role in the care and support of the patient but who is not professionally involved;
t) whether the patient is known to any MAPPA meeting or agency and, if so, in which area, for what reason, and at what level - together with the name of the Chair of any MAPPA meeting concerned with the patient, and the name of the representative of the lead agency;
u) in the event that a MAPPA meeting or agency wishes to put forward evidence of its views in relation to the level and management of risk, a summary of those views (or an Executive Summary may be attached to the report); and where relevant, a copy of the Police National Computer record of previous convictions should be attached;
v) whether, and if so how, any risks could be managed effectively in the community;
w) whether it is necessary for the welfare of the patient, or for the protection of others, that the patient should remain under guardianship and, if so, why;
x) any recommendations to the tribunal, with reasons.

D. CONDITIONALLY DISCHARGED PATIENTS

25. 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. Other conditions may, in addition, be imposed by the tribunal, or by the Secretary of State (Ministry of Justice).

26. This part only applies to restricted patients who have actually been granted a Conditional Discharge and who are living in the community. In the case of a restricted patient detained in hospital, the tribunal may make a provisional decision to order a Conditional Discharge. Before it finally grants a Conditional Discharge, the tribunal may defer its decision so that satisfactory arrangements can be put in place. Unless and until the tribunal finally grants a Conditional Discharge, the patient remains an in-patient, and so the in-patient part of this Practice Direction (and not this part) applies.

27. Upon being notified by the tribunal of an application or reference, the Responsible Clinician must send or deliver the Responsible Clinician's Report, and any Social Supervisor must send or deliver the Social Circumstances Report. If there is no Social Supervisor, the Responsible Clinician's report should also provide the required social circumstances information.

28. The required reports, which must contain the specified information, are:

- *Responsible Clinician's Report, including any relevant forensic history.*

- *Social Circumstances Report from the patient's Social Supervisor, including details of any Section 117 aftercare plan and, where appropriate, the additional information required for patients under the age of 18, and any input from a Multi Agency Public Protection Arrangements (MAPPA) agency or meeting*.

29. The reports must be sent or delivered to the tribunal so that they are received by the tribunal as soon as practicable and in any event within 3 weeks after the Responsible Clinician or Social Supervisor (as the case may be) received the notification.

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

31. The authors of reports should have personally met and be familiar with the patient. If an existing report is more than six weeks old, or if the status or the circumstances of the patient change after the reports have been written but before the tribunal hearing takes place (e.g. if a patient is recalled), the author of the report should then send to the tribunal an addendum addressing the up-to-date situation and, where necessary, the new applicable statutory criteria.

Responsible Clinician's Report – Conditionally Discharged Patients

32. The report must be up-to-date, specifically prepared for the tribunal and have numbered paragraphs and pages. It should be signed and dated. The report should be written or counter-signed by the patient's Responsible Clinician. If there is no Social Supervisor, the Responsible Clinician's report should also provide the required social circumstances information. The sources of information for the events and incidents described must be made clear. This report should not be an addendum to (or reproduce extensive details from) previous reports, or recite medical records, but must briefly describe the patient's recent relevant medical history and current mental health presentation, and must include:

a) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;
b) details of the patient's index offence(s), and any other relevant forensic history;
c) details and details of the patient's relevant forensic history;
d) a chronology listing the patient's involvement with mental health services including any admissions to, discharge from and recall to hospital;
e) reasons for any previous recall following a Conditional Discharge and details of any previous failure to comply with conditions;
f) the circumstances leading up to the current Conditional Discharge;
g) any conditions currently imposed (whether by the tribunal or the Secretary of State), and the reasons why the conditions were imposed;
h) details of the patient's compliance with any current conditions;
i) whether the patient is now suffering from a mental disorder and, if so, what the diagnosis is and why;
j) whether the patient has a learning disability and, if so, whether that disability is associated with abnormally aggressive or seriously irresponsible conduct;
k) details of any legal proceedings or other arrangements relating to the patient's mental capacity, or their ability to make decisions or handle their own affairs;
l) details of any appropriate and available medical treatment prescribed, provided, offered or planned for the patient's mental disorder;
m) the strengths or positive factors relating to the patient;
n) a summary of the patient's current progress, behaviour, capacity and insight;
o) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication or comply with any appropriate medical treatment for mental disorder;
p) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;
q) an assessment of the patient's prognosis, including the risk and likelihood of a recurrence or exacerbation of any mental disorder;
r) the risk and likelihood of the patient re-offending and the degree of harm to which others may be exposed if the patient does re-offend;
s) whether it is necessary for the patient's health or safety, or for the protection of others, that the patient should receive medical treatment and, if so, why;
t) whether the patient, if absolutely discharged, would be likely to act in a manner harmful to themselves or others, whether any such risks could be managed effectively in the community and, if so, how;
u) whether it continues to be appropriate for the patient to remain liable to be recalled for further medical treatment in hospital and, if so, why;
v) whether, and if so the extent to which, it is desirable to continue, vary and/or add to any conditions currently imposed;
w) any recommendations to the tribunal, with reasons.

Social Circumstances Report – Conditionally Discharged Patients

33. The report must be up-to-date, specifically prepared for the tribunal and have numbered paragraphs and pages. It should be signed and dated. The sources of information for the events and incidents described should be made clear. This report should not be an addendum to (or reproduce extensive details from) previous reports, but must briefly describe the patient's recent relevant history and current presentation, and must include:

a) the patient's full name, date of birth, and current address;
b) the full official name of the Responsible Authority;
c) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly;
d) details of the patient's index offence(s), and any other relevant forensic history;
e) a chronology listing the patient's involvement with mental health services including any admissions to, discharge from and recall to hospital;
f) any conditions currently imposed (whether by the tribunal or the Secretary of State), and the reasons why the conditions were imposed;
g) details of the patient's compliance with any past or current conditions;
h) the patient's home and family circumstances;
i) the housing or accommodation currently available to the patient;
j) the patient's financial position (including benefit entitlements);
k) any employment or available opportunities for employment;
l) details of the community support or Section 117 after-care that is being, or could be made available to the patient, together with details of the current care plan;
m) whether there are any issues as to funding the current or future care plan and, if so, the date by which those issues will be resolved;
n) the current adequacy and effectiveness of the care plan;
o) the strengths or positive factors relating to the patient;
p) a summary of the patient's current progress, compliance, behaviour and insight;
q) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;
r) the patient's views, wishes, beliefs, opinions, hopes and concerns;
s) the views of any partner, family member or close friend who takes a lead role in the care and support of the patient but who is not professionally involved;
t) whether the patient is known to any Multi Agency Public Protection Arrangements (MAPPA) meeting or agency and, if so, in which area, for what reason, and at what level - together with the name of the Chair of any MAPPA meeting concerned with the patient, and the name of the representative of the lead agency;
u) in the event that a MAPPA meeting or agency wishes to put forward evidence of its views in relation to the level and management of risk, a summary of those views (or an Executive Summary may be attached to the report); and where relevant, a copy of the Police National Computer record of previous convictions should be attached;
v) in the case of an eligible compliant patient who lacks capacity to agree or object to their placement or treatment, whether or not deprivation of liberty under the Mental Capacity Act 2005 (as amended) would be more appropriate;
w) whether the patient, if absolutely discharged, would be likely to act in a manner harmful to themselves or others, whether any such risks could be managed effectively in the community and, if so, how;
x) whether it continues to be appropriate for the patient to remain liable to be recalled for further medical treatment in hospital and, if so, why;
y) whether, and if so the extent to which, it is desirable to continue, vary and/or add to any conditions currently imposed;
z) any recommendations to the tribunal, with reasons.

E. PATIENTS UNDER THE AGE OF 18

34. All the above requirements in respect of statements and reports apply, as appropriate, depending upon the type of case.

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

a) the names and addresses of any people with parental responsibility, and how they acquired parental responsibility;
b) which public bodies either have worked together 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 those issues will be resolved;
g) the name and contact details of the patient's Care Co-ordinator, Community Psychiatric Nurse, Social Worker/AMHP or Social Supervisor;
h) whether the patient's needs have been assessed under the Children Act 1989 or the Chronically Sick and Disabled Persons Act 1970 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 such an assessment, what needs or requirements have been identified and how those needs or requirements 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;
    - the identity of any person(s) with whom the local authority shares parental responsibility;
    - whether there are any proceedings which have yet to conclude and, if so, the court in which 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;
    - 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 other 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 a child who has a mental disorder) under Section 17(11) of the Children Act 1989, the period or periods for which the child has 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;
q) if a patient is a child provided with accommodation under Sections 85 and 86 of the Children Act 1989, what steps have been taken by the accommodating authority or the person carrying on the establishment in question to discharge their notification responsibilities, and what steps have been taken by the local authority to discharge their obligations under Sections 85, 86 and 86A of the Children Act 1989.