MENTAL HEALTH REVIEW TRIBUNAL FOR WALES

PRACTICE DIRECTION

STATEMENTS AND REPORTS FOR MENTAL HEALTH REVIEW TRIBUNALS IN WALES

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1. In this Practice Direction "the Act" refers to the Mental Health Act 1983 (as amended by the Mental Health Act 2007). "The Rules" refer to the Mental Health Review Tribunal for Wales Rules 2008.

2. Rule 15 of the Rules sets out the steps that the Tribunal, a Responsible Authority and the Secretary of State must take when the Tribunal receives an application or a reference under the Act by reference to the Schedule to the Rules Parts A, B, C and D. *(Rule 15 and the Schedule are set out in full in the Appendix to the Practice Direction).*

3. This Practice Direction is intended to clarify the requirements of Rule 15 and the Schedule to the Rules and sets out the additional information that the Tribunal requires by reference to 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. In addition to the Rules this Practice Direction also takes into account the provisions of the Mental Health (Wales) Measure 2010, the Social Services and Well-being (Wales) Act 2014 and the Mental Health Act 1983 Code of Practice for Wales 2016.

CAROLYN KIRBY OBE — PRESIDENT, MHRT FOR WALES

SIR WYN WILLIAMS — PRESIDENT OF WELSH TRIBUNALS

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GENERAL REQUIREMENTS

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 If an existing report becomes out-of-date, or if the status or the circumstances of the patient change after the reports have been written but before the tribunal hearing takes place, the author of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

6. All reports must be up-to-date, be specifically prepared for the Tribunal and have numbered paragraphs and pages. Reports should be signed and dated. The sources of information for the events and incidents described must be made clear. Reports should not recite details of medical records or be an addendum to (or reproduce extensive details from) previous reports.

7. All medical reports should specifically address the relevant statutory criteria relied upon to support continued detention under the Act.

8. The purpose of this Practice Direction is to ensure that all persons providing or adducing evidence to the Tribunal shall be aware of a duty to assist the Tribunal in achieving the Overriding Objective set out in Rule 3 of the MHRT Wales Rules 2008 and in carrying out its statutory duties. Any failure to provide the information required by this Practice Direction within the time limits specified, may result in the Tribunal issuing further Directions in accordance with Rules 18 or 19 requiring specified information to be provided and/or by Summons requiring the attendance of a person to appear before the Tribunal.

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

9. 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.

10. In the case of a restricted patient detained in hospital, the tribunal may make a provisional decision to order a Conditional Discharge but may defer its decision until 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.

Statement of Information about the Patient - In-patients

11. In addition to the information set out in Part A of the Schedule to the Rules the responsible authority must provide the following:

    (a) details of any previous tribunal hearings and the outcome thereof;

(b) whether the patient suffers from any disability which will mean he requires assistance to take part in the tribunal process

(c) in the event that the patient lacks capacity to object to the nearest relative being informed of the hearing, a statement to that effect and details of the nearest relative;

(d) the name and address of any legal representative of the patient;

(e) a nursing report.

Responsible Clinician's Report – In-patients

12. The report should be written or countersigned by the patient's Responsible Clinician. It 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 and in particular whether the patient has the capacity to attend and be represented at a tribunal hearing;

(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) the strengths or positive factors relating to the patient;

(g) a summary of the patient's current progress, behaviour, capacity and insight;

(h) 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;

(i) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(j) 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;

(k) whether the patient, if discharged from hospital, would be likely to act in a manner dangerous to themselves or others;

(l) whether, and if so how, any risks could be managed effectively in the community, including the use of any lawful conditions or recall powers;

(m) any recommendations to the tribunal, with reasons.

Nursing Report – In-Patients

13. The report should be written or countersigned by the patient's named nurse. 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 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) 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) any recommendations to the tribunal, with reasons.

Social Circumstances Report – In-Patients

14. The report should where possible be written or countersigned by the patient's Care Coordinator. Where the Social Circumstances Report is not written by the Care Coordinator a separate report by the Care Coordinator should be provided giving the

information set out in s.18 of the Mental Health (Wales) Measure 2010 including an up-to-date Care and Treatment Plan. The Social Circumstances Report 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 previous response to community support or Section 117 aftercare;

(e) 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;

(f) the likely adequacy and effectiveness of the proposed care plan;

(g) whether there are any issues as to funding the proposed care plan and, if so, the date by which those issues will be resolved;

(h) the strengths or positive factors relating to the patient;

(i) a summary of the patient's current progress, behaviour, compliance and insight;

(j) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(k) the patient's views, wishes, beliefs, opinions, hopes and concerns;

(l) except in restricted cases, the views of the patient's Nearest Relative unless (having consulted the patient) it would be inappropriate or impractical to consult the Nearest Relative, in which case reasons for this view must be given and any attempts to rectify matters described;

(m) 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;

(n) 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;

(o) 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;

(p) 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;

(q) 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;

(r) whether the patient, if discharged from hospital, would be likely to act in a manner dangerous to themselves or others;

(s) whether, and if so how, any risks could be managed effectively in the community, including the use of any lawful conditions or recall powers;

(t) any recommendations to the tribunal, with reasons.

(B) COMMUNITY PATIENTS

15. For the purposes of this Practice Direction a patient is a Community Patient if the patient has been discharged from hospital under s.17A of the Act subject to the power of recall in accordance with s.17E. It includes a patient who has been recalled to hospital but whose CTO has not been revoked in accordance with s.17F.

16. In addition to the reports required in accordance with Schedule 1 Part B to the Act the responsible authority must provide a Nursing Report in relation to all community patients. The Nursing Report should be written by the professional person with the main responsibility for supervising the patient's treatment in the community. In the event that neither the Social Circumstances Report nor the Nursing Report are written by the patient's Care Coordinator the responsible authority should also provide a report by the Care Coordinator giving full details of the performance of their functions under s.18 of the Mental Health (Wales) Measure 2010 together with the up-to-date Care and Treatment Plan for the patient.

Statement of Information about the Patient – Community Patients

17. In addition to the information required under Part A of the Schedule to the Rules the Statement should also include;

(a) a chronological table listing;

(i) 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);

(ii) the date of the underlying order or Direction for detention in hospital prior to the patient's discharge onto the current CTO;

(iii) the date of the current CTO;

(iv) 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;

(v) the dates and outcomes of any tribunal hearings over the last three years;

(b) where 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, 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;

(c) 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;

(d) 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 include, so far as it is applicable the information set out above in relation to in-patients and, in addition;

(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) the circumstances leading up to the patient's discharge onto a CTO;

(c) the conditions to which the patient was made subject under Section 17B when the CTO was put in place and details of any variation of those conditions since then;

(d) details of the patient's compliance with the conditions imposed under s.17B together with details of any recalls to hospital under s.17E which have not resulted in a revocation of the CTO;

(e) any recommendations to the tribunal, with reasons.

Social Circumstances Report – Community Patients

19. The report must include the information set out in Part B of the Schedule to the Rules, so far as applicable the information required in relation to in-patient reports as set out in paragraph 14 above and, in addition, must include:

(a) The professional status of the report writer (e.g. AMHP, CPN), their position in relation to the patient's care and treatment in the community and details of the contact between the report writer and the patient since implementation of the CTO;

(b) the views of any other person professionally involved in the care and treatment of the patient in the community;

(c) details of the patient's compliance with the conditions imposed under s.17B and of any incidents where the patient has been recalled to hospital under s.17E but where the CTO has not been revoked under s.17F;

(d) whether the patient, if discharged from the CTO, would be likely to act in a manner dangerous to themselves or others;

(e) whether, in the professional opinion of the report writer, it continues to be necessary that the Responsible Clinician should be able to exercise the power of recall and, if so, why;

(f) any recommendations to the tribunal, with reasons.

(C) GUARDIANSHIP PATIENTS

20. For the purposes of this Practice Direction a Guardianship Patient is any patient who has been received into Guardianship in accordance with s.7 of the Act and where the Guardianship Order has not been discharged either in accordance with s.23 or s.6 (4) of the Act. For the avoidance of doubt it includes a patient who, during the currency of a Guardianship Order, is admitted to hospital informally for treatment or is admitted to hospital under ss. 2 or 4 of the Act.

21. In addition to the Statement of Information required by Part A of the Schedule to the Rules and the reports required in accordance with Part B the responsible authority are also required to provide a Nursing Report by the Managers of any residential facility in which the patient is required to live as a condition of the Guardianship Order.

Statement of Information about the Patient – Guardianship Patients

22. The statement provided to the tribunal should, in addition to the information required by Part A of the Schedule to the Rules, also include;

    (a) a chronological table listing:

        (i) the dates of any previous admissions to, discharge from or recall to hospital, stating whether the admissions were compulsory or voluntary;

        (ii) the dates of any previous instances of reception into guardianship;

        (iii) the dates and outcomes of any tribunal hearings over the last three years;

    (b) 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;

    (c) 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. In addition to the information required by Part B of the Schedule to the Rules the report 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) the strengths or positive factors relating to the patient;

(g) a summary of the patient's current progress, behaviour, capacity and insight;

(h) 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;

(i) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(j) 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;

(k) any recommendations to the tribunal, with reasons.

Social Circumstances Report – Guardianship Patients

24. In addition to the information required under Part B of the Schedule to the Rules the report should 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) any requirements to which the patient is subject under Section 8(1), and details of the patient's compliance,

(e) the patient's previous response to community support;

(f) details of the community support that is being, or could be, made available to the patient, together with details of the current care plan;

(g) the current adequacy and effectiveness of the care plan;

(h) 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;

(i) the strengths or positive factors relating to the patient;

(j) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(k) the patient's views, wishes, beliefs, opinions, hopes and concerns;

(l) the views of the guardian;

(m) the views of the patient's Nearest Relative unless (having consulted the patient) it would be inappropriate or impractical to consult the Nearest Relative, in which

case reasons for this view must be given and any attempts to rectify matters described;

(n) 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;

(o) 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;

(p) 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;

(q) whether, and if so how, any risks could be managed effectively in the community;

(r) 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;

(s) any recommendations to the tribunal, with reasons.

Nursing report – Guardianship Patients

25. The report should be prepared by the Manager of any residential facility in which the patient is required to live as a condition of the Guardianship Order and should include:

(a) the nature of any nursing or other care and medication currently being made available to the patient;
(b) the level of observation to which the patient is currently subject if any;
(c) whether the patient has contact with relatives, friends or other patients, the nature of the interaction, and what community support the patient has;
(d) strengths or positive factors relating to the patient;
(e) a summary of the patient's current progress, engagement with staff, behaviour, cooperation, activities, self-care and insight;
(f) any occasions on which the patient has been absent without leave whilst subject to the Guardianship Order;
(g) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication care or treatment that is or might be made available;
(h) any recommendations to the tribunal, with reasons.

(D) CONDITIONALLY DISCHARGED PATIENTS

26. For the purposes of this Practice Direction 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).

27. 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.

28. Upon being notified by the Minister of Justice of an application or reference, the Responsible Clinician must send or deliver to the Minister of Justice the Responsible Clinician's Report, and any Social Supervisor must send or deliver to the Minister of Justice the Social Circumstances Report. If there is no Social Supervisor, the Responsible Clinician's report should also provide the required social circumstances information. In addition the Responsible Clinician may send any further report if in the opinion of the Responsible Clinician such reports are likely to help the Tribunal when they consider the matter. The reports of the Responsible Clinician and Social Supervisor should address the criteria set out in paragraph 57 in **R(SC) v. MHRT [2005] EWHC 17 (Admin).**

Statement of Information – Conditionally Discharged Patients

29. The statement provided to the Tribunal should include the information set out in Part C of the Schedule to the Rules.

Responsible Clinician's Report – Conditionally Discharged Patients

30. 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. In addition to the information set out in Part D of the Schedule to the Rules, the report 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) a chronology listing the patient's involvement with mental health services including any admissions to, discharge from and recall to hospital;

    (d) reasons for any previous recall following a Conditional Discharge and details of any previous failure to comply with conditions;

    (e) the circumstances leading up to the current Conditional Discharge;

    (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 current conditions;

    (h) 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;

    (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;

(l) details of any incidents where the patient has harmed themselves or others, or threatened harm, or damaged property, or threatened damage;

(m) an assessment of the patient's prognosis, including the risk and likelihood of a recurrence or exacerbation of any mental disorder;

(n) 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;

(o) 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;

(p) 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;

(q) whether, and if so the extent to which, it is desirable to continue, vary and/or add to any conditions currently imposed;

(r) any recommendations to the tribunal, with reasons.

Social Circumstances Report – Conditionally Discharged Patients

31. In addition to the information required by Part D of the Schedule to the Rules the report should also include the following:

(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) 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;

(w) 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;

(x) whether, and if so the extent to which, it is desirable to continue, vary and/or add to any conditions currently imposed;

(y) any recommendations to the tribunal (with reasons).

Reports from the Ministry of Justice in Respect of Conditionally Discharged Patients

32. In accordance with Part D of the Schedule to the Rules the report will include the following;

(a) The view of the Secretary of State as to the suitability of the patient for absolute discharge.

(b) Any other observations on the application which the Secretary of State wishes to make.

(E) PATIENTS UNDER THE AGE OF 18

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

34. In accordance with the Code of Practice for Wales 2016, if the patient is under 18 and the RC is not a CAMHS specialist, the RC will need to ensure a report from such a specialist is provided to the Tribunal.

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, the Chronically Sick and Disabled Persons Act 1970 or the Social Services and Wellbeing (Wales) Act 2014 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:

(i) the date and duration of any such order;

(ii) the identity of the relevant local authority;

(iii) the identity of any person(s) with whom the local authority shares parental responsibility;

(iv) 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;

(v) whether the patient comes under the Children (Leaving Care) Act 2000 or the Social Services and Well-being (Wales) Act 2014.

(vi) 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;

(vii) 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 either Section 20 of the Children Act 1989 or under Section 76 of the Social Services and Well-being (Wales) Act, when the child became looked after, why the child became looked after, what steps have been taken to appoint an independent visitor for the child under Section 16 of the Children and Young Persons Act 2008 or under Section 98 of the Social Services and Wellbeing (Wales) Act 2014 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 or Section 39 (2) of the Social Services and Wellbeing (Wales) Act 2014.

(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.

APPENDIX

MENTAL HEALTH REVIEW TRIBUNAL FOR WALES RULES 2008

RULE 15 Statements, reports and documents

(1) Subject to Rule 17 (withholding documents or information likely to cause harm), when the Tribunal receives a document from any party it must send a copy of that document to each other party.

(2) When the Tribunal receives an application or reference it must send to the responsible authority or the Secretary of State, as the case may be, a request for the documents and information required to be provided under paragraph (3), (4) or (5).

(3) In proceedings under section 66 (1) (a) of the Act (application for admission for assessment), on the earlier receipt of the copy of the application or receipt of a request from the Tribunal, the responsible authority must send or deliver to the Tribunal by the commencement of the hearing –

(i) the application for admission;

(ii) the written medical recommendation or recommendations, as the case may be, of the registered medical practitioners on which the application is founded;

(iii) such of the information specified in Part A of the Schedule as is within the knowledge of the responsible authority and can reasonably be provided in the time available; and

(iv) such of the reports specified in Part B of the Schedule as can reasonably be provided in the time available.

(4) If the patient is a conditionally discharged patient the Secretary of State shall send to the Tribunal as soon as practicable, and in any event within 6 weeks of receipt by the Secretary of State of a copy of the application or request from the Tribunal, a statement which shall contain –

(a) the information specified in Part C of the Schedule, in so far as it is within the knowledge of the Secretary of State; and

(b) the reports specified in Part D of the Schedule, in so far as it is reasonable practicable to provide them.

(5) If neither paragraph (3) nor (4) applies, the responsible authority must send a statement to the Tribunal as soon as reasonably practicable, and in any event within 3 weeks of receipt by the responsible authority of a copy of the application or receipt of a request from the Tribunal, a statement which shall contain –

(a) the information specified in Part A of the Schedule, in so far as it is within the knowledge of the responsible authority;

(b) the report specified in paragraph 1 of Part B of that Schedule; and

(c) the other reports specified in Part B of the Schedule, in so far as it is reasonably practicable to provide them.

(6) If the patient is a restricted patient the responsible authority must also send the statement under paragraph (5) to the secretary of State, and the Secretary of state must send a statement of any further relevant information to the Tribunal as soon as reasonably practicable and in any event –

(a) in proceedings under section 75 (1) of the Act, within 2 weeks of receipt by the Secretary of State of the relevant authority's statement; or

(b) otherwise, within 3 weeks of receipt by the Secretary of State of the relevant authority's statement.

(7) If the Welsh Ministers or Secretary of State wish to seek the approval of the Tribunal under section 86 (3) of the Act, the Welsh Ministers or Secretary of State, as the case may be, must refer the patient's case to the Tribunal and the provisions of these Rules applicable to references under the Act apply to the proceedings.

SCHEDULE

STATEMENTS BY THE RESPONSIBLE AUTHORITY AND THE SECRETARY OF STATE

Part A Information about patients (other than conditionally discharged patients)

1. The patient's full name (and any alternative names used in patient records).
2. The patient's date of birth and age.
3. The patient's language of choice and, if it is not English or Welsh, whether an interpreter is required.
4. The application, order or direction made under the Act to which the tribunal proceedings relate and the date on which that application, order or direction commenced.
5. Details of the original authority for detention or guardianship of the patient, including the statutory basis for that authority and the details of any subsequent renewal of or change in that authority.
6. In cases where a patient has been transferred to hospital under section 45A, 47 or 48 of the Act, details of the order, direction or authority under which the patient was being held in custody before his transfer to hospital.

7. Except in relation to a patient subject to guardianship or after-care under supervision, or a community patient, the hospital or hospital unit at which the patient is presently liable to be detained under the Act, and the ward or unit on which he is presently detained.
8. If a condition or requirement has been imposed that requires the patient to reside at a particular place, details of the condition or requirement and the address at which the patient is required to reside.
9. In the case of a community patient, details of any conditions attaching to the patient's community treatment order under section 17B (2) of the Act.
10. The name of the patient's responsible clinician and the length of time the patient has been under their care.
11. Where another approved clinician is or has recently been largely concerned in the treatment of the patient, the name of that clinician and the period the patient has spent in that clinician's care.
12. The name of any care coordinator appointed for the patient.
13. Where the patient is subject to the guardianship of a private guardian, the name and address of that guardian.
14. Where there is an extant order of the superior court of record established by section 45 (1) of the Mental Capacity Act 2005, the details of that order.
15. Unless the patient requests otherwise, the name and address of the person exercising the functions of the nearest relative of the patient.
16. Where a local health board, a National Health Service trust, a primary care trust, a NHS Foundation Trust, a Strategic Health Authority, the Welsh Ministers or the Secretary of State has or have a right to discharge the patient under the provisions of section 23 (3) of the Act, the name and address of such board, trust, authority, person or persons.
17. In the case of a patient subject to after-care under supervision, the name and address of the local social services authority and NHS body that are responsible for providing the patient with after-care under section 117 of the Act, or will be when he leaves hospital.
18. The name and address of any person who plays a substantial part in the care of the patient but who is not professionally concerned with it.
19. The name and address of any other person who the responsible authority considers should be notified to the Tribunal.

Part B Reports relating to patients (other than conditionally discharged patients)

1. An up to date clinical report, prepared for the Tribunal, including the relevant clinical history and a full report of the patient's mental condition.
2. An up to date social circumstances report prepared for the Tribunal including reports on the following –

   (a) the patient's home and family circumstances, including the views of the patient's nearest relative or person so acting;

   (b) the opportunities for employment or occupation and the housing facilities which would be available to the patient if discharged;

(c) the availability of community support and the relevant medical facilities;

(d) the financial circumstances of the patient.

3. The views of the responsible authority on the suitability of the patient for discharge.
4. Where the provisions of section 117 of the Act may apply to the patient, a proposed after-care plan in respect of the patient.
5. Any other information or observations on the application which the responsible authority wishes to make.

Part C Information about conditionally discharged patients

1. The patient's full name (and any alternative names used in patient records).
2. The patient's date of birth and age.
3. The patient's language of choice and, if it is not English or Welsh, whether an interpreter is required.
4. The history of the patient's present liability to detention including details of the offence or offences, and the dates of the original order or direction and of the conditional discharge.
5. The name and address of any clinician responsible for the care and supervision of the patient in the community, and the period that the patient has spent under the care and supervision of that clinician.
6. The name and address of any social worker or probation officer responsible for the care and supervision of the patient in the community and the period that the patient has spent under the care and supervision of that person.

Part D Reports relating to conditionally discharged patients

1. Where there is a clinician responsible for the care and supervision of the patient in the community, an up to date report prepared for the Tribunal including the relevant medical history and a full report on the patient's mental condition.
2. Where there is a social worker, probation officer or community psychiatric nurse responsible for the patient's care and supervision in the community, an up to date report prepared for the Tribunal on the patient's progress in the community since discharge from hospital.
3. A report on the patient's home circumstances.
4. The views of the Secretary of State on the suitability of the patient for absolute discharge.
5. Any other observations on the application that the Secretary of State wishes