Somerset Partnership NHS
NHS Foundation Trust

FIRST TIER TRIBUNAL (MENTAL HEALTH)

POLICY AND GUIDANCE

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DOCUMENT CONTROL

<table>
<tr><td>Reference
BJ/Oct/10/FTTP&G</td><td>Version
4</td><td>Status
Final</td><td colspan="2">Author
Mental Health Act Coordination Lead</td></tr>
<tr><td>Amendments</td><td colspan="4">Policy author changed from MH Legal Strategies lead to MHA Coordination Lead
All references to social workers and allied healthcare professionals removed (no need for a distinction between them and care coordinators)
Definition provided of ‘responsible authority’
Clarification provided about who can apply for a Tribunal- including at 5.3 an explanation about the new ‘late’ application procedure defined by caselaw.
More detail about when to refer cases to the Secretary of State- a point which has received national attention following the publication of the new Code of Practice in April 2015. The Trust sought guidance from the DoH, and this is included as an appendix.
New guidance about action to take when a patient refuses to access a solicitor or lacks the capacity to instruct one.
Guidance about when the Trust may wish to seek its own legal representation at a Tribunal.
New guidance about the contents of reports based on a practice direction issued by the tribunal service in 2013.
Section 9 incorporates the new process being used by the Tribunal office to set hearing dates.
Guidance about the new rules around preliminary examinations by medical members.
Information about the new appeals process via the Upper Tribunal.
Policy now complies with and makes explicit reference to the new MHA Code of Practice (2015) and Reference Guide.</td></tr>
<tr><td colspan="5">Document objectives: To inform staff of the First Tier Tribunal process and their responsibilities before and during Tribunals</td></tr>
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<tr><td colspan="5">Monitoring arrangements and indicators: The Trust will collate review issues arising from First Tier Tribunal activity.</td></tr>
<tr><td colspan="5">Training/resource implications: The Trust will ensure all relevant staff, that is those providing reports for and attending First Tier Tribunals, are appropriately trained in the writing of reports. The Mental Health Act CoordinationLead or other nominated person will provide training for relevant staff.</td></tr>
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1. INTRODUCTION

1.1 The Tribunal is an independent judicial body. Its main purpose is to review the cases of detained, conditionally discharged, and supervised community treatment patients under the Mental Health Act and to direct the discharge of any patients where it thinks it appropriate. It also considers applications for discharge from guardianship.

1.2 The Tribunal provides a significant safeguard for patients who have had their liberty curtailed under the Mental Health Act. Those staff giving evidence at hearings should do what they can to help enable Tribunal hearings to be conducted in a professional manner, which includes having regard to the patient's wishes and feelings and ensuring that the patient feels as comfortable with the proceedings as possible.

1.3 Care should be given to ensuring all information provided for a Tribunal is as up to date as possible to avoid adjournment. All information must be clear and concise.

2. PURPOSE AND SCOPE

2.1 The First Tier Tribunal (Mental Health) policy and guidance is written to provide information about Tribunals and ensure practitioners enable patients to fulfill their right of appeal against their detention. Appendix 1 to the policy/guidance details when patients can appeal and there is a section in the main body of the policy/guidance on how to challenge the decision of a Tribunal within the legislative powers available.

2.2 The policy also clarifies legislation and guidance in respect of preparation and participation in the overall appeal process as it affects both Responsible Clinicians and those giving evidence in respect of the patient's social circumstances. Detailed guidance is provided in Appendices B and C on how reports should be written and presented.

3. DUTIES AND RESPONSIBLITIES

3.1 The **Trust Board** has a duty to ensure patients are able to appropriately exercise their right of appeal under Part V of the Mental Health Act 1983. As **Responsible Authority** the Trust must ensure reports for Tribunals are produced in a timely and satisfactory manner and appropriate clinicians attend the Tribunal hearing.

3.2 The **Director of Governance and Corporate Governance** is responsible for this policy covering First Tier Tribunals, but will delegate authority for the operational implementation and ongoing management of this policy to the Mental Health Legal Strategies Lead.

3.3 **Care Coordinators, Responsible Clinicians** and **In-patient Coordinator / Keyworkers** are responsible for report writing

3.4 The **Mental Health Act Coordination Lead** is the author of this policy, who will review this policy at least every two years.

3.5 Each **registered healthcare professional** is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence and work within the Code of practice of their professional body.

3.6 **All staff** involved in the First Tier Tribunal process should be familiar with the procedures detailed in the document and other related policies.

3.7 **Line managers** are responsible for ensuring all staff are conversant with this policy and related policies.

4. EXPLANATIONS OF TERMS USED

RC – Responsible Clinician

Responsible Authority- the body responsible for providing the Tribunal with information and reports. For patients detained in a Somerset Partnership hospital, or subject to a CTO where The Partnership are the managers of the responsible hospital, The Somerset Partnership NHS Foundation Trust is the responsible authority.

Nearest Relative – As defined in section 26 of the MHA '83

Tribunal –The First-tier Tribunal. It is an independent judicial body established under the Tribunals, Courts and Enforcement Act 2007. Among its many functions, the Health, Education and Social Care (HESC) Chamber of the First-tier
Tribunal exercises powers under the Mental Health Act 1983 which, prior to 3 November 2008, belonged to the Mental Health Review Tribunal (MHRT). Specifically, it has the power to decide whether patients should continue to be detained (or be liable to be detained) under the Act, continue to be on a CTO, or remain subject to guardianship, as applicable.
In-patient Coordinator / Keyworker - The patient's named Nurse/ care-coordinator

CTO – Community Treatment Order – An order under S.17A of the Mental Health Act, applicable to some patients previously detained under S.3 or S.37.

5. APPLICATION TO THE FIRST TIER TRIBUNAL

Patients and nearest relatives have the right to appeal to the Tribunal in certain circumstances. Hospital managers have a duty to make 'automatic' referrals in cetain circumstances. The Secretary of State may at any time refer the case of most detained patients, and all CTO patients, to the Tribunal.

Each of these responsibilities/duties are explained below, and Appendix A contains an explanation of who may apply/refer and when.

Applications by patients

5.1 An application is made to the First Tier Tribunal either through the Trust's Mental Health Act Administration office, or the patient can appeal direct or through their solicitor (see Appendix A for who can appeal and when).

5.2 Staff in the Trust should make every effort to help the patient (either directly or via their advocate) understand their rights of appeal and should help them appeal against their detention. This might involve, where the time scales to appeal are tight, allowing the patient use of a Trust fax machine. The Trust will ensure throughout the Tribunal process all service users or patients, together with their relatives or carers as appropriate, are able to fully understand the Tribunal process and this may necessitate the provision of information and communications in a language or format they can easily understand including the use of a professional interpreter or translator.

5.3 A patient subject to Section 2 may only lodge an appeal within the first 14 days of their detention (In the case of a patient who is already in hospital, the day the patient is admitted means the day on which the application is received by the hospital managers. For patients transferred from outside England or Wales, it means the day on which they are treated as having been admitted to the hospital in England or Wales.). Sometimes the 14th day will fall on a weekend or bank holiday when no one will be available within the MHA administration office to send the referral on to the Tribunal service. In that situation the referral request should be faxed or e-mailed to the MHA administrators in the usual way as soon as it is made by the patient, and the Tribunal Service will accept the referral as valid if it is received on the first working day after the weekend/bank holiday. Patients must not be told to delay their request until after the weekend/bank holiday if doing so means that their referral would be made after 14 days have elapsed since their detention began. Staff should telephone the MHA administrators as soon as possible on the first working day after the weekend/bank holiday to ensure that the referral is made urgently.

Applications by nearest relatives

5.4 Nearest relatives may only apply to the Tribunal in very specific circumstances. See Appendix A for details. Any nearest relative who wishes to make a referral should be provided with information about how to make a referral, and should be directed to the MHA administration team for guidance. The guidance in paragraph 5.2 above applies.

'Automatic' referrals by the hospital managers

5.5 Hospital managers are under a duty to refer a patient's case to the Tribunal in the circumstances set out in section 68 of the Act, summarised in Appendix B.

5.6 The Mental Health Act administrators will coordinate these referrals as detailed in the Trust's 'Scheme of Delegation of Hospital Managers' Functions', and monitoring of this will be done via the annual MHA audit plan.

References by The Secretary of State for Health

5.7 The Secretary of State for Health may at any time refer the case of most detained patients, and all CTO patients, to the Tribunal. Anyone may request such a reference, and the Secretary of State will consider all such requests on their merits.

5.8 The Code of Practice provides guidance at para 37.46 about when hospital managers should consider asking the Secretary of State to make a reference.

5.9 The Trust will always (via the MHA administrators) seek a reference from the Secretary of State when a patient's detention under section 2 has been extended under section 29 of the Act pending the outcome of an application to the county court for the displacement of their nearest relative.

5.10 The Code recommends that hospital managers should seek a reference in any case where the patient lacks the capacity to request a reference. The Department of Health has informed the Trust that "*this refers to cases where there may be a particular reason why a referral should be made before the next hospital managers' statutory referral is due.*" RCs must exercise their discretion about what a 'particular reason' may be, and should (via the MHA administrators) seek a reference from the Secretary of State whenever they consider it appropriate. See Appendix C for a copy of the correspondence received from the DoH, which includes a link to its own guidance on this matter.

5.11 In cases where a detained patient lacks the capacity to make a referral to the Tribunal a referral for an IMHA should be made.

6. SECTION 117 AFTER CARE

6.1 In line with the Trust's section 117 policy, patients detained under one of the relevant sections who are due to be heard by a First Tier Tribunal should have, as far as is possible, a section 117 Care Plan prepared for the Tribunal. The more likely it is that the Tribunal or Hearing will discharge the patient, the more detail that will be required within the care plan. It will help the process of providing written and oral evidence to the Tribunal, especially where the nature or degree of the patient's mental disorder is such that the provision of after-care would be feasible or likely to prove very difficult.

7. LEGAL REPRESENTATION

7.1 Where the patient intends to make an application to the First Tier Tribunal, the following must be considered:

7.2 There is a regularly updated list of solicitors approved by The Law Society as able to act for patients pertaining to their compulsion under the Mental Health Act 1983. A copy of this list is available on each ward or from each Mental Health Act Administration office.

7.3 The patient might ask staff to recommend a legal representative. In this situation, staff should ask the patient to choose from the list and should not recommend a

particular legal representative.

7.4 If the patient refuses or seems unable to choose a legal representative, then the RC should send a short statement to the MHA administrators about the patient's capacity to make this decision. The MHA administration team will forward this statement to the Tribunal Service. If the RC has stated that the patient has the capacity to refuse a solicitor then none is appointed. If the RC states that the patient lacks capacity to instruct (or not instruct) a solicitor, then the Tribunal Office will appoint a solicitor to represent the patient at the hearing.

7.5 All discussion and action should be documented in the patient's notes.

7.6 Once the legal representative has been appointed, s/he will contact the ward to arrange a time to see the patient.

7.7 Where practicable, staff should arrange for a suitable room to be available, which is private, safe and which does not contain any confidential information.

7.8 On arrival the legal representative should show appropriate identification and make it known whom it is they are to see.

7.9 There may be occasions when legal representatives arrive at the ward without an appointment, i.e. if they are on site having seen a client and want to pass on some information to another client while in the vicinity. Where practicable, every effort should be made to accommodate this meeting.

7.10 Once the patient has instructed the legal representative, s/he will usually give written permission for the legal representative to view their medical case notes to help prepare the case. This should be sent, either by the solicitor or via the ward, to the Information, Governance and Records Manager, who will log the request and send back to the ward so that the patient's records can be checked (see the Trust's 'Record Keeping and Records Management' Policy).

7.11 The Trust does not allow advertising in the form of posters or the distribution of business cards, other than those given to their client. This is to ensure that all patients see the full list of available legal representatives and make a free choice as to which representative they would like to contact.

7.12 Legal representatives should never be allowed to access areas where patient information is stored or displayed.

7.13 As in all other situations staff should never share information about patients to anyone unless they have the authority to do so.

7.14 If a legal representative arrives on the ward or telephones to make an appointment to see a particular patient, staff should first check to see that the patient has, in fact, instructed the legal representative; it should never just be assumed. This may necessitate a request for the solicitor to show proof of their instruction, a call to the Mental Health Act Administration office, and/or asking the patient for confirmation.

7.15 Unsolicited visits or telephone calls are not permitted according to The Law Society Solicitor's Publicity Code 2001, as amended 13January 2003.

7.16 If there is any doubt regarding issues connected with a patient's legal representation, staff should seek advice from their manager and/or the Mental Health Act Administration office.

7.17 The Code of Practice states at paragraphs 12.31 and 32:
"Responsible clinicians can attend the hearing solely as a witness or as the nominated representative of the responsible authority. As a representative of the responsible authority, the responsible clinician has the ability to call and cross-examine witnesses and to make submissions to the Tribunal. This may not always be desirable where it is envisaged that the responsible clinician will have to continue working closely with a patient.

Responsible authorities should therefore consider whether they want to send an additional person to represent their interests, allowing the responsible clinician to appear solely as a witness. Responsible clinicians should be clear in what capacity they are attending the Tribunal, as they may well be asked this by the panel."

7.18 The Trust, though it will have witnesses appearing in a clinical and social care capacity, is not automatically represented at a Tribunal. Any witness intending to act as such must make this known to the Tribunal and Mental Health Act Administration prior to the commencement of the Hearing. If it felt that formal legal representation is required because of the complex nature of the case, the Director of Governance and Corporate Development should be informed as soon as possible. If appropriate, they will ensure a solicitor represents the Trust employee. See 11.4 below.

7.19 The RC must ensure the patient fully understands the Tribunal procedure and process and, if necessary, should consider the use of a professional translator or interpreter to ensure this is the case.

8. TRIBUNAL REPORTS- See Appendix E For Trust guidance on report-writing.

8.1 It is the responsibility of the Responsible Clinician (RC), or whichever doctor provides the medical report, to ensure that the reports in respect of medical issues concerning the patient are of sufficient quality.

8.2 It is the responsibility of the Ward Manager to ensure that nursing reports are of sufficient quality.

8.3 It is the responsibility of the relevant team manager to ensure that social circumstances reports are of sufficient quality.

8.4 There are too many report templates to include as appendices to this policy. Trust templates are available either from the MHA administration team or on the intranet. An appropriate report template will be sent to each report author by the MHA administration team.

8.5 Reports prepared and sent electronically do not require a physical signature. They must, however, clearly state the author's name and the date the report was written.

8.6 As soon as the Mental Health Act Administration department is made aware of the application, requests will be made to the Responsible Clinician and relevant Team for reports. All report writers will be sent a report template relevant to the patient's detention status. The template must be followed.

8.7 There is a statutory responsibility on the Responsible Authority to provide the Tribunal with all relevant reports within three weeks of receipt of the tribunal's request for reports. The Tribunal office requires copies of the reports.Upon receipt, the Mental Health Act Administration department will arrange for the copies to be made and sent to the Tribunal office. Mindful of the tighter time scales, reports for patients detained on S.2 should be completed as soon as is practicable. See Appendix D which contains the Tribunal Service's directions about the receipt of reports.

8.8 In the case of a restricted patient, it is essential that copies of all reports be sent directly from the Trust to the Ministry of Justice. The Mental Health Act Administration department will arrange for this to be done.

8.9 The Trust (and individual report authors) will be vulnerable to legal challenge where the statutory time scales as to the provision of reports are not met, particularly where the hearing is delayed or adjourned for late or non-receipt of reports. See Appendix D.

8.10 Any document/report not for disclosure to the patient should be annotated clearly and a written explanation attached as to the reasons for requesting non-disclosure. A separate document, which can be shown to the patient, should be submitted. The Tribunal will consider carefully the request for non-disclosure and all the issues involved before deciding whether to override the wishes of the author of the report. The Tribunal will only agree to non-disclosure where there are compelling reasons to do so, and where they are convinced that 'disclosure would adversely affect the health or welfare of the patient or others'. All reports will however be made available to the patient's legal representative although he/she will be bound by any ruling of the Tribunal. Any information to the patient must be in a format which they can easily understand. This may involve translation into a different format.

8.11 Note that section 76 of the Mental Health Act authorises any registered medical practitioner (doctor) instructed by or on behalf of the patient, to visit the patient at any reasonable time, make an examination in private and inspect any records relating to the compulsion powers and treatment of that patient. Although not a legal requirement, prior to the visit, the independent doctor should have made contact with the Responsible Clinician and/or ward giving notice. If this does not happen, or other independent professionals have been asked to examine the patient, the Responsible Clinician should be notified immediately.

8.12 If the patient has recently been or is shortly to be transferred between wards, this information must be communicated to the Mental Health Act Administration office. The referring Responsible Clinician and ward must also inform the receiving Responsible Clinician and ward that the patient has made an application for appeal. If not already done so, a discussion must take place between the two Responsible Clinicians, and a decision made as to who will be providing the medical report and who will be attending the hearing itself. This must be communicated to the Mental Health Act Administration office.

8.13 There may be situations where a patient's transfer to us or away from us should await the outcome of a pending Tribunal. Discussions between the current RC and prospective RC about this decision should involve the Tribunal Service so that the RC can take into account the implications for the patient of any possible Tribunal delay which would be caused by a move between hospitals.

9. SETTING THE DATE OF THE HEARING

9.1 Hearing dates are set by the Tribunal Office, and there is limited scope for negotiation. The MHA administration team carry out the liaison with the Tribunal Office on behalf of the Trust.

9.2 When an application is submitted for a section 2 appeal, the Tribunal Office will make contact, normally within 24 hours, offering a date and time for the hearing to take place which will be within the 7 days' 'listing window' (7 days after the application is received by the tribunal office). The Trust is given only 4 hours to respond to this date and if we do not respond within that time, a date will be imposed upon us.
If an RC cannot accommodate this date, we have to provide valid reasons and ask for further dates. If we request that a hearing take place after the 7 days, the MHA administration team completes a CMR1 form in which we have to provide an explanation and reasons for having the hearing outside the 7 days. This is then given to a Judge and they will make the decision whether to grant the postponement or to refuse it. If they refuse it and impose the original date, there is nothing we can do to get them to change it.

9.3 When an application is submitted for a treatment order appeal (Section 3, 37/41 etc) the Tribunal Office will make contact with the MHA administration team via email and will ask for the RC's availability over a specific 4 week period. The Tribunal Office does not ask about the availabilty of any other report authors. The MHA administrators will then liaise with the RC and submit dates to the Tribunal Office on an HQ1 form. Concurrently the Tribunal Office will have requested the same information from the patient's solicitor and when both sets of information have been returned to the Tribunal Office, they will try and match availability for both parties and set a date for a hearing.

9.4 An application can be withdrawn at any time by the patient/applicant subject to the Tribunal accepting the withdrawal. The request should be made in writing to the Tribunal office. Where the patient is represented he/she will be approached and encouraged to make contact with their client to discuss the request.

9.5 Where the patient is not represented and they request a withdrawal the Regional Chair will be advised of the request, and will decide whether or not it should be accepted.

9.6 The Tribunal office will advise where a Tribunal has been cancelled, for whatever reason, but practitioners should never assume that the Tribunal hearing is cancelled without notification from the Tribunal office.

9.7 The Trust will ensure it makes any necessary adjustments, such as meeting any disability or sensory impairment needs, for those attending the Tribunal.

9.8 If an interpreter is required the MHA administration team must be informed as soon as possible so that this can be arranged through the Tribunal Office.

10 THE TRIBUNAL MEDICAL MEMBER

10.1 The medical member will always visit the patient before a section 2 hearing. This does not happen automatically for any other hearing. A patient subject to a treatment order or a Community Treatment Order must apply via their solicitor for such a preliminary examination. This request must be made 14 days before the date of the hearing otherwise it will be refused.

10.2 Ward staff (or the care co-ordinator for CTO patients) must ensure that the medical member can see patients in private, where this is safe and practicable, and make provision for the member and the Tribunal panel at the hearing to be able to examine the patient's medical records, if necessary. It is important that the patient is told of any visit in advance, so that they can be available when the medical member visits.

10.2 The medical member will contact the ward or care coordinator to make arrangements to see the patient before the hearing, explaining who he or she is, the purpose of the visit, and time and date. It is important that the patient is told of the visit in advance and is present on the ward (or at another agreed location for CTO patients) when the medical member visits. If the patient is on leave of absence the ward should make arrangements for the patient to return to the ward for the medical examination.

10.3 The Tribunal office should be informed immediately of a patient's discharge from section. If this happens outside office hours it is helpful if a nurse from the ward leaves a message on the Tribunal office's answering machine, particularly where a hearing is set for the following day.

10.4 Where a patient refuses to be examined by the medical member of the Tribunal, the medical member will inform the Tribunal office.

11. THE HEARING

11.1 The hearing is conducted in private unless the patient requests a public hearing and the Tribunal accepts the request. If a patient's request for a public hearing is accepted by the Tribunal the Director of Governance and Corporate

Development must be informed immediately.

11.2 The Trust, via a service Level Agreement, provides a clerking service to the Tribunal where we are the responsible authority. This service will usually be provided by a MHA administrator, but may, by prior arrangement when an administrator is not available, be provided by a member of staff on site

11.3 The Tribunal will seek to avoid formality to help put the patient at ease. Normally the patient will be present throughout the hearing, unless one of the parties requests otherwise and the Tribunal agree and accept that the presence of the patient at a particular stage will adversely affect the patient's health or the welfare of the patient or others. The Tribunal has the power to exclude any person from the hearing or part of the hearing, subject to the provisions in Rule 38(4) of the First Tier Tribunal (Health, Education and Social Care) Rules 2008 (Part 4).

11.4 Rule 36 of the First Tier Tribunal (Health, Education and Social Care Chamber) Rules 2008 (Part 4) allows for any party to be represented (including the Responsible Authority). Careful consideration should be given in each case as to whether or not the Trust wishes to be represented, and the implications of being a representative for the individual concerned. Any authorised representative will be expected to stay for the entire hearing, and will have the same rights as the patient's representative to examine witnesses, including the patient, and to address the Tribunal Panel. The patient or their representative will however always be given the final word.

11.5 The Tribunal will expect to see the Responsible Clinician or a deputy who knows the patient and in the opinion of the Responsible Clinician has sufficient knowledge and experience of the patient and psychiatry to represent the responsible authority.

11.6 It is essential that an appropriate professional who knows the patient well attends the hearing to give further, up to date information about the patient, home circumstances and after-care facilities in the event of a decision to discharge. Failure by the hospital to ensure that the appropriate professionals attend the hearing, as above, will usually be treated by the Tribunal as a serious matter, possibly requiring an explanation by the Trust's Chief Executive Officer and potentially a subpoena for the absent party.

12. THE TRIBUNAL'S DECISION

12.1 Tribunals are encouraged to announce the decision immediately after the hearing. On occasions where the patient has gone back to the ward or their community setting, the decision may be conveyed to the solicitor who is expected to communicate this to their client the same day. It is important that where the patient is discharged that he or she and a representative of the hospital is also advised. A completed form 6 will be given to the clerk by the Tribunal judge. The clerk will distribute to the patient and all professionals involved in the Hearing.

12.2 If the Tribunal makes statutory recommendations e.g. for transfer to another hospital, for leave of absence, the hospital is not legally obliged to follow them,

but the tribunal can reconvene at a later stage to find out why their recommendations have not been followed, and rehear the matter as appropriate.

12.3 The Tribunal's decision must be communicated to the patient in a format which can be easily understood. This may involve the use of a professional translator or interpreter to ensure this is the case.

13. ADJOURNMENTS

13.1 A Tribunal has the power to adjourn a hearing. This may be for further information in the form of reports or for a witness to attend a reconvened hearing. Directions may be made as to when and how the information should be provided, and for the issuing of a subpoena if necessary. A Tribunal cannot adjourn to monitor a patient's progress.

13.2 If the Tribunal issues Directions, the Mental Health Act Administrators will be responsible for ensuring that the appropriate people are aware of their need to comply.

14. CHALLENGING THE DECISION OF A FIRST TIER TRIBUNAL

There are two formal means of challenging a Tribunal's decision:
a) Via an appeal to The Upper Tribunal

14.1 Appeals to the Upper Tribunal may only be made on a point of law, and only with the permission of the First-tier Tribunal or the Upper Tribunal itself. Before deciding whether to grant permission to appeal, the First-tier Tribunal will first consider whether to review its own decision.

14.2 If it upholds an appeal, the Upper Tribunal may make a new decision itself, or it may remit the case back to the First-tier Tribunal to be heard again.

14.3 On appeal to the Upper Tribunal, the respondent is any person other than the appellant who was a party before the First-tier Tribunal or otherwise has a right of appeal against the decision of the First-tier Tribunal. In practice, this means that in unrestricted cases the responsible authority is the respondent in any case in which the patient (or, where relevant, the patient's nearest relative) seeks permission to appeal to the Upper Tribunal, and in cases involving restricted patients, the respondent is both the responsible authority and the Secretary of State for Justice.

14.4 Responsible authorities have the same right to appeal against decisions of the First-tier Tribunal as the patient and any other parties to the case. The Trust will seek formal legal advice in cases where the RC or care co-ordinator believes an appeal should be lodged.

b) Judicial Review

14.5 No application for judicial review will be considered by the High Court unless a High Court judge has first granted leave. To obtain leave, an application must be filed promptly and within three months of the decision to be challenged. Judicial review is not an appeal against the Tribunal's finding of facts.

14.6 The purpose of the proceedings is most usually to persuade the court to quash the Tribunal's decision on the grounds that it has acted unlawfully (made an error in interpreting/applying the law), irrationally (reached a decision that no reasonable Tribunal could possibly have reached), or improperly (failed to act in accordance with the rules of natural justice). If a decision is quashed, the court has the power to remit the case back to the Tribunal with a direction that it be reconsidered in accordance with the court's judgment.

14.7 In *R v Ashworth Hospital Authority and Others ex Parte H*, the Court of Appeal held that the Court had jurisdiction to stay the Tribunal's decision, but that such discretion should be used sparingly, and, wherever possible, the judicial review application should be determined *"within days"* of the stay. The court can grant the stay even after the decision of the tribunal has been implemented; so for instance if the Tribunal had directed the discharge of a patient and that patient had subsequently left the hospital premises, the stay can still be made and the patient therefore could be returned to hospital under the authority of section 18.

14.8 If a stay was not to be imposed, then, unless the Tribunal had been unaware of material circumstances indicating compulsion when making its discharge order, the Tribunal's view had to prevail unless and until quashed by a court.

14.9 Professionals seeking to 'resection' a patient before the court hearing would need to satisfy themselves that their sole or principal ground for resection was not one that the Tribunal had rejected in substance and it was in accordance with the House of Lords judgment in the *von Brandenburg* case, where it was held that for this to happen the AMHP in the case must have formed the reasonable and bona fide opinion that s/he now had information not known to the Tribunal which put a significantly different complexion on the case as compared with that which was before the tribunal.

14.10 Should any situation arise where consideration is being given to challenge the decision of a First Tier Tribunal, it should be discussed with a member of the Mental Health Act Administration team and ultimately with the Director of Nursing, who can instruct a solicitor where appropriate.

15. TRAINING REQUIREMENTS

15.1 Training will be provided for those required to produce reports for First-Tier Tribunals (Mental Health): Responsible Clinicians, Care Coordinators and Nurse Key Workers. Training needs will be assessed by line manager and provided by the Mental Health Act Coordination Lead, or another nominated person.

16. EQUALITY IMPACT ASSESSMENT

16.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in

this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

17. MONITORING COMPLIANCE AND EFFECTIVENESS

Monitoring arrangements for compliance and effectiveness

17.1 The Trust will monitor issues arising from First Tier Tribunal activity via the Mental Health Legislation Group. Overall monitoring will be by the Regulation Governance Group. The Mental Health Legislation Group is a sub-group of and accountable to the Regulation Governance Group.

Responsibilities for conducting the monitoring

17.2 The Chair of the Regulation Governance Group will ensure feedback reports from the Mental Health Legislation Group are timetabled within the Regulation Governance Group reporting schedule and present on appropriate agenda.

17.3 The Mental Health Legislation Group will monitor procedural compliance and effectiveness where they relate to First Tier Tribunals and feedback to the Regulation Governance Group.

Methodology to be used for monitoring

17.4 Regular discussions of the following will be recorded within the MHL Group minutes

- complaints monitoring
- incident reporting and monitoring via DATIX
- new significant risks to be reported to the Regulation Governance Group by the MHA Group

17.5 **Frequency of monitoring**

- half-yearly reports to the Mental Health Act Group
- half-yearly Risk reporting to the Regulation Governance Group
- half-yearly reporting of Lessons Learnt to the Regulation Governance Group
- Lessons learned will be fed back to Community BPG, IQIS and SW AMHPs as appropriate

17.6 **Process for reviewing results and ensuring improvements in performance occur.**

Issues arising will be discussed at the MHL Group who will identify good practice, any shortfalls, action points and lessons learnt. The outcome of the issues and any change in policy will be presented to the Senior Managers Operational Group who will be responsible for ensuring improvements, where necessary, are implemented.

18 COUNTER FRAUD

The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

19. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

19.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

19.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents

19.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

20. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

References

Jones R.'Mental Health Act Manual – 16th Edition – Sweet & Maxwell 2013
MHA '83 Code of Practice – – The Department of Health 2015The Reference Guide to the MHA '83- The Department of Health 2015

Cross reference to other procedural documents

Consent & Capacity to Consent Treatment policy
Record Keeping and Records Management Policy
Section 117 policy

Section 17 leave policy
Community Treatment Order policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

21 APPENDICES

21.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A	Applications to First Tier Tribunals – Part II and III Patients
Appendix B	Hospital managers' duties to refer cases to the Tribunal
Appendix C	e-mail received from the Department of Health on 16 April 2015 re referring certain cases to the secretary of State.
Appendix D	Directions from The Tribunals Judiciary re the submission of reports- April 2015
Appendix E	Guidance for the preparation of reports for First-tier Tribunals

APPENDIX A

Somerset Partnership NHS Foundation Trust

APPLICATIONS TO FIRST TIER TRIBUNALS – PART II PATIENTS

Category of Admission or Circumstance	Maximum Duration	Application to Tribunals by Patient	Application to Tribunals by Nearest Relative	Automatic Reference by the Hospital Managers	Comments
Admission for assessment (s.2)	Up to 28 days	Once within first 14 days of admission	No	No (but see comments)	Hospital managers have a duty to refer after 6 months to the Tribunal those Section 2 patients whose detention has been extended as a result of an application to the County Court for the displacement of the Nearest Relative
Admission for treatment (s.3)	Up to 6 months, renewable for 6 months and 12 months thereafter	Once within first 6 months, once within second 6 months and once in each 12 month period thereafter	No	On renewal if the Tribunal have not considered case in first 6 months (Including any time under section 2). Also if the Tribunal has not considered case for 3 years (1 year if a child under 18)	Change to those statements in brackets effective from 3rd November 2008
Emergency admission (s.4)	Up to 72 hours	Once (including any period following conversion to s.2)	No	No	
Doctor's holding power (s.5(2))	Up to 72 hours	No	No	No	
Nurse's holding power (s.5(4))	Up to 6 hours	No	No	No	
Guardianship (s.7)	Up to 6 months, renew for 6 months and then every 12 months	Once within first 6 months, once within second 6 months and once in each 12 month period thereafter	No	No	

Category of Admission or Circumstance	Maximum Duration	Application to Tribunals by Patient	Application to Tribunals by Nearest Relative	Automatic Reference by the Hospital Managers	Comments
Patient transferred from guardianship to hospital (s.19)	Remainder of original duration under Guardianship then as section 3 above	Once within the initial period and once in each period thereafter.	No	On renewal if the Tribunal have not considered case in first 6 months. Also if the Tribunal has not considered case for 3 years (1 year if a child under 16)	
Nearest relative barred from discharging patient (s.25)		No	s.2 – No s.3 – within 28 days of report	No	
Nearest Relative displaced by County Court (s.29)		No	Once within the first year following displacement and in each subsequent year	No	But this rule does not apply to a Nearest relative who has been 'displaced' on the grounds that there is no identifiable nearest relative or their incapacity; they will have no right to apply to the Tribunal for the Patients discharge
Patients subject to Community Treatment Orders and liable to be recalled (S17A)	Up to 6 months, renewable for 6 months and 12 months thereafter	Once within first 6 months, once within second 6 months and once in each 12 month period thereafter. If the order is revoked, within the period of six months starting on the day the order is revoked	No	If the order is revoked or on renewal if the Tribunal have not considered case in first 6 months (Including any time under section 2). Also if the Tribunal has not considered case for 3 years (1 year if a child under 18)	

APPLICATION TO FIRST TIER TRIBUNALS – PART III PATIENTS

Category of Admission	Maximum Duration	Application to the Tribunal by the Patient	Application to the Tribunal by the Nearest Relative	Automatic Reference by the Hospital Managers
Sections 35, 36, 38, 44	Various	No	No	No
Guardianship Order (s.37)	Up to 6 months, renewable for 6 months and 12 months thereafter	Once within first 6 months, once within second 6 months and once in each 12 month period thereafter	Once within the period of 12 months beginning with the date of the order and once in each 12 month period thereafter	No
Hospital Order (s.37)	Up to 6 months, renewable for 6 months and 12 months thereafter	Once in second 6 months and once in each 12 month period thereafter	Once in second 6 months and once in each 12 month period thereafter	If the Tribunal have not considered case for 3 years (1 year if a child under 16)
Hospital Order with Restriction Order (ss.37 & 41)	Usually without limit of time	Once after 6 months and once in each 12 month period thereafter	No	If the Tribunal have not considered case for 3 years (1 year if a child under 16)
Conditionally Discharged Restricted Patient	Usually without limit of time	Once after 12 months following discharge and once every 2 years thereafter	No	If the Tribunal have not considered case for 3 years (1 year if a child under 16)
Conditionally Discharged Restricted Patient who has been recalled to hospital under s.42 (ss.37 & 41)	Usually without limit of time	Once after 6 months and once in each 12 month period thereafter	No	Home Secretary must refer to the Tribunal within 1 month of recall
Hospital Direction (s.45A)	Dependant on sentence	Once after 6 months and once in each 12 month period thereafter	No	If the Tribunal have not considered case for 3 years

Category of Admission	Maximum Duration	Application to the Tribunal by the Patient	Application to the Tribunal by the Nearest Relative	Automatic Reference by the Hospital Managers
Transfer from Prison to Hospital (ss.47 or 48)	Variable	Once within first 6 months and once in each 12 month period thereafter	Once in second 6 months and once in each 12 month period thereafter	If the Tribunal have not considered case for 3 years
Transfer from Prison to Hospital with Restrictions (ss.47 or 48 with s.49)	Variable	Once within first 6 months and once in each 12 month period thereafter	No	If the Tribunal have not considered case for 3 years
Patients remaining in hospital under s.37 on expiration of Restriction Order	Up to 6 months, renewable for 6 months and 12 months thereafter	Once within first 6 months, once within second 6 months and once in each 12 month period thereafter	Once within first 6 months, once within second 6 months and once in each 12 month period thereafter	If the Tribunal have not considered case for 3 years
Hospital Order under Criminal Procedure (Insanity) Act (s. 5(1))	Up to 6 months, renewable for 6 months and 12 months thereafter	Once within first 6 months, once within second 6 months and once in each 12 month period thereafter		If the Tribunal have not considered case for 3 years (1 year if a child under 16)
Hospital Order with restriction Order under Criminal Procedure (Insanity) Act (s. 5(1))	Usually without limit of time	Once within first 6 months and once in each 12 month period thereafter	No	If the Tribunal have not considered case for 3 years (1 year if a child under 16)

APPENDIX B

Hospital managers' duties to refer cases to the Tribunal

Hospital managers must refer the following patients	When
Patients who are detained under part 2 of the Act, and patients who were detained under part 2 but are now CTO patients	Six months have passed since they were first detained, unless: • the patient applied to the Tribunal themselves after they became a section 3 patient • the patient's nearest relative applied to the Tribunal after the responsible clinician barred the nearest relative's order to discharge a section 3 patient • the patient's displaced nearest relative has applied to the Tribunal after the displacement order is made • the patient's case was referred to the Tribunal by the Secretary of State for Health after the patient became a section 3 patient, or • the managers have already referred the patient's case to the Tribunal because their community treatment order was revoked (see below). (If the patient is still a section 2 patient, pending the outcome of an application to the county court for a change in their nearest relative, there are no exceptions)
Patients who are detained under part 2 of the Act, or were detained under part 2 but are now CTO patients	Three years have passed since their case was last considered by the Tribunal (one year if they are under 18)
People who were CTO patients but whose CTOs have been revoked	As soon as practicable after the responsible clinician revokes the CTO
Patient was transferred from guardianship to a hospital	Six months have passed, unless the patient has already applied to the Tribunal after being transferred from guardianship to a hospital
Patients detained under hospital orders, hospital directions or transfer directions under part 3 of the Act without being subject to special restrictions (collectively, unrestricted part 3 patients), or who were detained under part 3 of the Act but are now CTO patients	Three years have passed without their case being considered by the Tribunal (one year if they are under 18)

Note: for these purposes:

- detention under part 2 of the Act does not include any time spent detained under the 'holding powers' in section 5 (see chapter 18), and
- applications to the Tribunal do not count if they are withdrawn before they are determined.

APPENDIX C

e-mail received from the Department of Health on 16 April 2015

I am sorry that you had to send a reminder about the enquiry that you had first submitted back in January. I have discussed the matter with my senior colleague.

There are provisions in the Act whereby the hospital managers have a duty to refer civil cases to the First-tier Tribunal under 68 of the Act ie within 6 months of first being detained under the Act and where 3 years have passed since the patient has had their case reviewed by the First-tier Tribunal. In 2010 we issued guidance about references to the Secretary of State under section 67 of the Mental Health Act 1983. This is available via the following link. https://www.gov.uk/government/publications/section-67-of-the-mental-health-act. There are currently no plans to update the guidance. However, the fax number that should now be used is 0115 902 3211 and this will be reflected in any update. Faxes sent to this number are received in the mentalhealthact2007@dh.gsi.gov.uk mailbox. A copy of the reference form can be downloaded from the Ministry of Justice website http://hmctsformfinder.justice.gov.uk/HMCTS/GetForm.do?court_forms_id=2734

The Department has received requests for section 67 references in respect of patients with dementia. With the support of an IMHA or another person such patients might be able to apply for a tribunal hearing themselves, within the prescribed time limits. Officials acting for and on behalf of the Secretary of State consider section 67 requests on a case by case basis and make referrals where the circumstances would warrant a First-tier Tribunal hearing. Of course, the detaining authorities should ensure that the criteria for compulsory treatment under the Act is being met and take action to discharge the individual where it is no longer the case.

With regard to the obligation to "consider" seeking a section 67 referral in Code paragraph 37.45,
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/396918/Code_of_Practice.pdf

this refers to cases where there may be a particular reason why a referral should be made before the next hospital managers' statutory referral is due. As the text is in the 2015 Code is exactly the same as the 2008 Code's paragraph 30.40, no impact would be expected.

I hope this is helpful.

Appendix D

Directions from The Tribunals Judiciary re the submission of reports

JUDGE MARK HINCHLIFFE
DEPUTY CHAMBER PRESIDENT
FIRST TIER TRIBUNAL (HEALTH EDUCATION AND SOCIAL CARE)
MENTAL HEALTH

16 April 2015

Dear Mental Health Act Administrator,

Re: Requirement to submit reports to the tribunal on time
I am writing to explain the new procedure that the Mental Health Tribunal is going to follow in relation to statements and reports for the tribunal, and the way in which we need you to help us. To deal with late reports, we are introducing a new HQ1 form, and it will be compulsory to use the new HQ1 from 5th May 2015. We should very much like you to discuss this letter with your Manager, whose support you may need.

The tribunal is looking to reduce the time it spends chasing after the Responsible Authority's written evidence (i.e. reports and 'Statement of Information') whilst, at the same time, adopting an efficient slimmed-down procedure that provides an effective sanction for non-compliance which is more immediate, proportionate and focussed than immediately summonsing witnesses, Chief Executives or Medical Directors. For this reason, the tribunal expects this approach to have your support.

The new Case Notification Letter (CNL1) will contain a direction requiring you to identify the Responsible Authority's witnesses in the new HQ1 at the start of the process. We have amended the HQ1 so that, on behalf of the Responsible Authority, you can provide us with the names and addresses (postal and email) of all the individuals, identified by you, as required to provide the required reports and the 'Statement of Information'. You may find it useful to do this at the same time that you notify the various report-writers etc that a report is required. We have also added a further requirement for you to advise the tribunal immediately if the details of the persons responsible for the reports or statement changes before the evidence is filed.

The report-writers you identify must include the authors of any 'out-of-area' social circumstances report – which it is still your legal responsibility to obtain. You will therefore need to contact the 'out-of area' office to find out the identity and contact details of the person who will be responsible for writing the 'out-of-area' report.

It will, of course, still be the job of the Responsible Authority or MHA Administrator to obtain and submit the reports etc within the 3 week period required by law. However, it is also **really important** that, at the same time, you provide **us** with the details of **all** the persons you have identified as being responsible for providing the Reports and the Statement. **We need this information from you, early on**.

The new also HQ1 directs you to certify that the information provided is correct at the time of writing, and can be relied upon by the tribunal for service of all directions and summonses.

So long as we have the accurate identity and contact details of all report-writers at an early stage, we can then (if necessary) immediately enforce compliance speedily and directly without further delay. But please note that if the required contact details are not provided on the new HQ1 and reports are late, we may then have no choice but to send our directions and summonses direct to the Chief Executive or Medical Director.

If a report or statement is late, this is what we will do. After the 3 week period has expired, we will send a direction to the late report-writer personally. We will generally give them a further 7 days to comply. However, there will be a warning to the person in default that if this direction is not complied with, we will consider referring the person to the Upper Tribunal for consideration of a penalty.

Rule 13 states that if a party provides an email address, then that person must accept delivery of documents by that method - so we will generally use the secure email address provided by you, on behalf of the Responsible Authority. This means that the information you give us must be accurate. If there is then a failure to comply with that personal 7 day direction (after the previous failure to submit the evidence within the 3 weeks), the tribunal will consider making a referral to the Upper Tribunal so that they can consider imposing a personal penalty against the late report-writer.

You may be interested to know that, if a referral is made, the Upper Tribunal has power to punish what amounts, in effect, to a contempt of court. Consequently, in a case called *CB v Suffolk CC [2011] AACR 22*, a fine of £500 was imposed on someone.

We will keep records of late report-writers who have previously failed to comply so that, if relevant, we can consider the witness's previous record when considering whether to make a referral to the Upper Tribunal for imposition of a penalty.

The new HQ1 will shortly be available on our HMCTS Form Finder page:
http://hmctsformfinder.justice.gov.uk/HMCTS/FormFinder.do
(Form/leaflet number: HQ1; or select 'Mental Health Tribunal' from 'Available types')
The new HQ1 **must** be used from 5th May 2015 and if you use the old form after that date, we will not accept it. I attach a copy for you which you should save as a template.

If you have any questions, please email: mhtreports@hmcts.gsi.gov.uk

Thank-you in anticipation of your help and cooperation.

Yours faithfully

Deputy Chamber President

GUIDANCE FOR THE PREPARATION OF REPORTS FOR THE FIRST TIER TRIBUNALS

Mental Health Act Administrators will send report templates to report writers at the time reports are requested. The template must be followed.

On 28 October 2013 The Tribunal Service issued a Practice Direction specifying the contents required within reports to The First Tier Tribunal (Mental Health). It has made some significant changes, and now requires more detail. Some of the topics are duplicated between reports, some will not be relevant for all patients and at least one is fiercely legally complicated. These concerns were raised with the Tribunal Service, and on 2 January 2014 Tribunal Judge Neville Chamberlain responded. His comments have been incorporated in this guidance, although he stressed that **"***I have not had time to consult with colleagues, so what I am giving you are my own views alone."*

The Trust has developed a set of report templates based on the Practice Direction (available via the MHA administrators), but these templates should be used with Judge Chamberlain's words in mind:

"Proforma reports. This is a vexed issue, because I know the forms are drawn up with the best of intentions. But it can lead to a situation in which most of the report is proforma, with just a word or two inserted under each heading by the author. Such reports are difficult to read - it is hard to disentangle the specific information from the proforma headings - but it can also lead to a situation in which the author of the report may think it is sufficient just to 'tick the box' by inserting a few words."

Ultimately what the Tribunal requires is information showing whether or not the grounds for detention remain, and what the alternatives to continued detention are.

Formatting and general points.

Although Judge Chamberlain is not a huge fan of report templates the Practice Direction is quite explicit in what it expects:

"The report must be up-to-date, specifically prepared for the tribunal and have

numbered paragraphs and pages. It should be signed and dated. If the author of the RC's report is not the RC themselves, then the RC must counter-sign the report. 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, but must briefly describe the patient's recent relevant history and current presentation."

Guidance on some of the new requirements

"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"

Both of these headings appear in Responsible Clinician's (RC's) reports and social circumstances reports.

Comment from Judge Chamberlain:

"(…) there is a difference between a subjective view and objective information. The Tribunal is always keen to have the personal view of the professional involved. However, there is absolutely no point in duplicating factual - especially chronological - information and, as long as the nurse or social worker is quite satisfied that the RC [for example] will include that information and that that information is correct, then it is entirely acceptable to specify in the report that that information will be given elsewhere. Of course, the nurse or social worker will sometimes have factual information which the RC does not; for example, in the case of a CTO patient whom the RC sees rarely but the social worker regularly. On a personal note, I find it extremely wearing to have to wade through lengthy duplicated

information, on the basis that there might be a fresh needle somewhere in the haystack. This is especially the case in restricted cases, where reports often contain vast amounts of information.

Trust recommendation: Authors of RC reports should include the chronology, because RCs are the people responsible for the patient's care and, ultimately whether or not the patient remains detained. Authors of social circumstances reports should liaise as early as possible with the author of the RC report to confirm that the chronology will be included.

"m) a summary of the patient's current progress, behaviour, compliance and insight"

On the question of whether 'capacity to understand and to consent to treatment' would be better wording than 'compliance and insight' Judge Chamberlain said:

" *I quite understand that difficult questions are raised by paragraph m). However the Tribunal is in my experience well able to deal with these issues; if the Tribunal does not raise them, then the legal representative almost certainly will. Firstly: the Tribunal is always very much helped by a simple view as to whether a patient, off-section, is currently likely to take medication voluntarily, with or without prompting and encouragement. I would encourage professionals always to provide the Tribunal with their opinion on that point. Secondly: the professionals can then if they wish go on to elaborate upon that view; that elaboration could quite properly deal with issues such as whether the situation has been adequately explained to the patient and, if not, whether the patient would agree to take medication if that were done."*

Trust recommendation: The terms 'compliance' and 'insight' derive from the medical model of mental disorder, and the Trust would expect authors of social circumstances reports to acknowledge this in their report. Authors of social circumstances reports should only use language and terms with which they are familiar and which they understand fully. Using the concepts of capacity, consent and willingness may therefore be more appropriate here. Authors of social circumstances reports may prefer to use the heading **'Willingness of the patient to accept and cooperate with the professionals' view of their mental disorder and proposed treatment.'**

"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"

This is an enormously complicated legal question to answer. For social circumstances report authors it is probable that only AMHPs or Best Interests Assessors would be able to even attempt it. Judge Chamberlain suggests:

"In my view it would be appropriate for it to be stated that the report's author cannot answer the question. However, I don't think there could be any objection to the author quoting the view of another professional on the topic, if that view were known"

Trust Recommendation: Authors of social circumstances reports should approach this question with caution, and the Trust agrees with the judge's opinion above. Social circumstances report authors should only address this question if they are sure that one or more of the criteria listed below is or are met. Ultimately it is for the Tribunal itself to make this judgement based on the evidence it has, and should not need the author of a social circumstances report to answer this question directly.

RCs should be able to answer this question, however, because if a DoLS authorisation is more appropriate, why has the patient not already been discharged from section? Potential answers (which incorporate guidance from the MHA Code of Practice) could be the following. Any one of these would be sufficient, but they will need to be edited before use in order to be personalised and not look like a cut and paste exercise. Apart from number 4, which will stand by itself.

1. "In my opinion the patient's current mental state, together with evidence of past experience, indicates a strong likelihood that they may soon regain the capacity to decide whether or not to accept treatment in hospital and would not consent to informal admission. Therefore, taking into account all the circumstances so far as they are reasonably ascertainable I believe that the patient should be considered to be objecting to their treatment for mental disorder in hospital.

The treatment they require amounts to a deprivation of their liberty, and this objection means that they are ineligible for an authorisation under the DoLS regime."

The above could be amended to take account of a vicarious objection coming from family/carers.

2. "A degree of restraint needs to be used which is justified by the risk to other people but which is not permissible under the MCA because, exceptionally, it cannot be said to be proportionate to the risk to the patient personally."

3. "The patient has, by means of a valid and applicable advance decision, refused a necessary element of the treatment required. The treatment, therefore, could not be provided under the MCA."

4. "The patient is aged under 18."

5. "The use of the safeguards would conflict with a decision of the patient's attorney or deputy or the Court f Protection."

6. "Whilst the patient lacks capacity to make decisions on some elements of the care and treatment he/she needs, he/she has capacity to decide about a vital element (e.g. admission to hospital) and has either already refused it or is likely to."

7. "There is some other specific identifiable risk that the patient might not receive the treatment they need if the MCA is relied on and that either the patient or others might potentially suffer harm as a result."

"Whether the patient, if discharged from hospital, would be likely to act in a manner dangerous to themselves or others" (a similarly worded question appears in CTO reports)

Trust Recommendation (with which Judge Chamberlain agrees): This is of relevance only where the nearest relative is appealing after having had their order of discharge barred by the responsible clinician. This is the only situation where the patient's potential 'dangerousness' becomes relevant. In other circumstances it is acceptable to say this question is not relevant, or omit it altogether. Any risks posed by the patient to themselves or others will be covered under the headings concerning risk management. It may be distressing for a patient to read or hear an opinion about their 'dangerousness' when this is irrelevant.

Nick Woodhead

Mental Health Act Coordination Lead