ISLE OF MAN MENTAL HEALTH REVIEW TRIBUNAL

GUIDANCE

Issued by the Chairmen of the Isle of Man Mental Health Review Tribunal on 19 June 2017 after Consultation with the High Bailiff, HM AG for the IoM, IoM Law Society, DHSC, Mental Health Professionals and patient support and advocacy groups.

Issue 1 coming into effect 01 July 2017

Revision and update (not used in this version).

A. INTRODUCTION

1. The Isle of Man Mental Health Review Tribunal ("the Tribunal") is established under the Mental Health Act 1998 ("the Act") and conducts its business and hearings in accordance with the Act, the Mental Health Regulations 2000 ("the Regulations") and the Mental Health Rules 2000 ("the Rules").

2. The Legislative and Regulatory regime has been in force for 16 years. Since the introduction of the Act, Regulations and Rules there have been changes in relation to Human Rights law and the Chairmen felt it would be of assistance to them, the staff who clerk for the Tribunal and parties who have to prepare for Tribunal hearings (including hospital staff and advocates) and appear before the Tribunal, to provide guidance as to best practice to attempt to ensure that Tribunal proceedings are conducted in accordance with the overriding objective as follows.

3. **The Overriding Objective**

(1) The overriding objective is to assist the Tribunal to deal with cases justly.

(2) Dealing with a case justly includes, so far as is practicable —

(a) ensuring that the parties are on an equal footing;

(b) saving expense;

(c) dealing with the case in ways which are proportionate to —

(i) the importance of the case;

(ii) the complexity of the issues; and

(iii) the needs and requirements of each party and in particular the health and safety of any patient who is before the Tribunal and the safety of third parties;

(d) ensuring that it is dealt with expeditiously and fairly; and

(e) allotting to it an appropriate share of the Tribunal's resources, while taking into account the need to allot resources to other cases.

(3) The Tribunal will attempt to give effect to the overriding objective when it exercises any power given to it by the Act, Regulations and Rules.

(4) The parties are required to help the Tribunal to further the overriding objective.

4. The Tribunal Service of the Isle of Man, in general, and the Tribunal in particular, is committed to value for money, transparency, accountability and to the delivery of the highest quality decision making and administration to Tribunal users and cooperating with other stakeholders such as Department of Health and Social Care, and any of its employees including Hospital Managers, doctors, nurses and social workers (together "the Department"), GP's, Doctors, Nurses, Social Workers (and others concerned in the treatment of patients under the Act), patients, Advocates and others who may represent or assist patients.

5. In 2017 it was thought appropriate, by the Chairmen after consultation with the Department, the Isle of Man Law Society and the High Bailiff (as ex officio Chairman of the Tribunal), and other stake holders for guidance and a statement of best practice to be issued as to how the Tribunal works and what is expected of parties who prepare papers for or appear as witnesses or representatives before the Tribunal.

6. These guidance notes are not rules, but are a statement of best practice. They should be observed wherever possible by the Tribunal members, Tribunal staff, the Department, Witnesses (including Doctors, nurses and social workers) and representatives of parties including patients. The Tribunal, within the Act, Regulations and Rules, always has the power to exercise discretion in case of difficulty and upon reasoned application or explanation. The guidance notes do not fetter that discretion.

7. The guidance should be read in conjunction with the Act, Regulations and Rules. In case of conflict the Act, Regulations and Rules prevail.

8. The guidance contains one general section for all types of application and specific sections listing variations, additional requirements or exceptions for particular applications or categories of patients.

B. GENERAL IN-PATIENTS

9. Unless one of the additional requirements or exceptions applies, the Department should send or deliver to the Tribunal the following documents containing the specified information in accordance with the paragraphs below:

    · Statement of Information about the Patient. This can be a separate document or contained within the Department's report.

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

    · Nursing Report, with the patient's current nursing plan attached.

    · Social Circumstances Report including details of any Care Pathway Approach ("CPA") and/or Section 115 aftercare plan in full or in draft.

10. In all in-patient cases, except where a patient is detained under Section 2 of the Act, the Department should send to the Tribunal the required documents containing the specified information, so that the Tribunal receives them as soon as practicable and in any event within 3 weeks (or such other period as the Tribunal shall specify in any particular case) after the Department made or received the application or reference. If the patient is a restricted patient, the Department must also, at the same time, send copies of the documents to the Department of Home Affairs.

11. Where a patient is detained under Section 2 of the Act, the Department must prepare the required documents as soon as practicable after receipt of a copy of the application or a request from the Tribunal and in no case later than 12 midday on the working day two days before the day appointed for the hearing. If specified information has to be omitted because it is not available, then this should be mentioned in the statement or report.

12. These documents must also be made available to the Tribunal panel and the patient's representative ("patient's representative" means, if unrepresented, the patient but if represented by an advocate, or other legal representative, or a patient advocacy group, such representative as is notified to the Tribunal or such other person nominated by the patient and approved by the Chairman) by the Tribunal service as soon as possible after receipt by them.

13. The authors of reports should have personally met and be familiar with the patient. If an existing report becomes out-of-date, or if the status or the circumstances of the patient change after the reports have been written but before the Tribunal hearing takes place (e.g. if a patient is discharged, or is recalled), the author of the report should where time permits send to the Tribunal an addendum addressing the up-to-date situation and, where necessary, the new applicable statutory criteria. If time does not permit they should notify the Tribunal at the hearing at the start of their evidence.

Statement of Information about the Patient – Department's Report

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

a) the patient's full name, date of birth, and usual place of residence;

b) the full official name of the Hospital and ward where the patient is detained;

c) the patient's first language/dialect and, if it is not English, whether an interpreter is required and, if so, in which language/dialect;

d) if the patient is deaf, or hearing impaired, whether the patient will require the services of British Sign Language Interpreters and/or a Relay Interpreter or a loop induction system;

e) 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 date when the current period of detention in hospital originally commenced, stating the nature of the application, order or direction that is the authority for the detention of the patient;

iii. the dates of any subsequent renewal of, or change in, the authority for the patient's detention, and any changes in the patient's status under the Act;

iv. the dates and details of any leave of absence granted in the previous 2 years and the dates and details of any hospital transfers since the patient's original detention;

v. the date of admission or transfer to the hospital where the patient now is;

vi. the dates and outcomes of any Tribunal hearings the Department are aware of;

f) the name of the patient's Responsible Clinician and the date when the patient came under the care of that clinician;

g) the name and contact details of the patient's Care Co-ordinator, Community Psychiatric Nurse, Social Worker/Approved Mental Health Professional or Social Supervisor;

h) the name and contact details of any legal representative believed to be acting for the patient;

i) the name and contact details of any patient support representative believed to be acting for the patient;

j) except in the case of a restricted patient, the name and address of the patient's Nearest Relative or of the person exercising that function, whether the patient has made any request that their Nearest Relative should not be consulted or should not be kept

informed about the patient's care or treatment and, if so, the details of any such request, whether the Department believes that the patient has capacity to make such a request and the reasons for that belief;

k) the name and address of any other person who plays a significant part in the care of the patient but who is not professionally involved; and

l) details of any legal proceedings or other arrangements relating to the patient's mental Capacity, or their ability to make decisions or handle their own affairs.

Responsible Clinician's Report

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

    a) whether there are any factors that may affect the patient's understanding or ability to cope with a hearing and whether there are any adjustments that the Tribunal may need to consider in order to deal with the case fairly and justly;

    b) details of any index offence(s) and other relevant forensic history;

    c) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital;

    d) reasons for any previous admission or recall to hospital;

    e) the circumstances leading up to the patient's current admission to hospital;

    f) whether the patient is now suffering from a mental disorder and, if so, whether a diagnosis has been made, what the diagnosis is, and why;

    g) whether the patient has a learning disability and, if so, whether that disability is associated with abnormally aggressive or seriously irresponsible conduct;

    h) depending upon the statutory criteria, whether any mental disorder present is of a nature or degree to warrant, or make appropriate, liability to be detained in a hospital for assessment and/or medical treatment;

    i) details of any appropriate and available medical treatment prescribed, provided, offered or planned for the patient's mental disorder;

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

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

    l) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication or comply with any appropriate medical treatment for mental disorder that is or might be made available;

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

    n) 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;

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

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

q) any recommendations to the Tribunal, with reasons.

Nursing Report

16. The report must be up-to-date, specifically prepared for the Tribunal and have numbered paragraphs and pages. It should be signed and dated. The name of the author, and any counter signatory, the name of the patient, the date of the report and the date of the hearing should appear on the front page of the report and at its end. The sources of information for the events and incidents described must be made clear. This report should not recite the details of medical records, or be an addendum to (or reproduce extensive details from) previous reports, although the patient's current nursing plan should be attached. In relation to the patient's current in-patient episode, the report must briefly describe the patient's current mental health presentation, and must include:

    a) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the Tribunal may need to consider in order to deal with the case fairly and justly;

    b) the nature of nursing care and medication currently being made available;

    c) the level of observation to which the patient is currently subject;

    d) whether the patient has contact with relatives, friends or other patients, the nature of the interaction, and what community support the patient has;

    e) strengths or positive factors relating to the patient;

    f) a summary of the patient's current progress, engagement with nursing staff, behaviour, cooperation, activities, self-care and insight;

    g) any occasions on which the patient has been absent without leave whilst liable to be detained, or occasions when the patient has failed to return as and when required, after having been granted leave;

    h) the patient's understanding of, compliance with, and likely future willingness to accept any prescribed medication or treatment for mental disorder that is or might be made available;

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

    j) any occasions on which the patient has been secluded or restrained, including the reasons why such seclusion or restraint was necessary;

    k) whether (in Section 2 cases) detention in hospital, or (in all other cases) the provision of medical treatment in hospital, is justified or necessary in the interests of the patient's health or safety, or for the protection of others;

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

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

n) any recommendations to the Tribunal, with reasons.

Social Circumstances Report

17. The report must be up-to-date, specifically prepared for the Tribunal and have numbered paragraphs and pages. It should be signed and dated. The name of the author, and any counter signatory, the name of the patient, the date of the report and the date of the hearing should appear on the front page of the report and at its end. The sources of information for the events and incidents described must be made clear. This report should not be an addendum to (or reproduce extensive details from) previous reports, but must briefly describe the patient's recent relevant history and current presentation, and must include:

    a) whether there are any factors that might affect the patient's understanding or ability to cope with a hearing, and whether there are any adjustments that the Tribunal may need to consider in order to deal with the case fairly and justly;

    b) details of any index offence(s) and other relevant forensic history;

    c) a chronology listing the patient's previous involvement with mental health services including any admissions to, discharge from and recall to hospital;

    d) the patient's home and family circumstances;

    e) the housing or accommodation available to the patient if discharged;

    f) the patient's financial position (including benefit entitlements);

    g) any available opportunities for employment;

    h) the patient's previous response to community support or aftercare;

    i) so far as is known, details of the care pathway and after-care to be made available to the patient, together with details of the proposed care plan;

    j) the likely adequacy and effectiveness of the proposed care plan;

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

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

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

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

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

    p) except in restricted cases, or cases where the Nearest Relative does not wish the patient to be told of their views and the Tribunal has ordered non-disclosure under Rule 12, 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 give reasons for this view and describe any attempts to rectify matters;

q) the views of any other person who takes a lead role in the care and support of the patient but who is not professionally involved;

r) the names of any other agencies involved with the patient e.g. probation, police, courts, Child and Adolescent Mental Health Services, Drug and Alcohol Team, Social Services or Children's Social Services;

s) 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;

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

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

v) any recommendations to the Tribunal, with reasons.

C. GUARDIANSHIP PATIENTS

18. **Variations**

a) the Senior (or such other Social Worker as the Department shall designate) Social Worker shall be responsible for the provision of the Statement of Information which would otherwise be prepared by the Department.

b) the Statement of Information shall additionally contain -

i. the dates of any previous instances of reception into guardianship;

ii. the date of reception into current guardianship, stating the nature of the application, order or direction that constitutes the original authority for the guardianship of the patient;

iii. the dates and outcomes of any Tribunal hearings over the last three years; and

iv. the name and address of any private guardian or Receiver.

19. **Responsible Clinician's Report – Guardianship Patients**

Variation

a) 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.

20. **Social Circumstances Report – Guardianship Patients**

Additions

a) the views of the guardian;

b) 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.

D. PATIENTS UNDER THE AGE OF 18

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

22. 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 115 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/Approved Mental Health Professional or Social Supervisor;

    h) whether the patient's needs have been assessed and proposals made under the Children and Young Persons Act 1966 to 2001 or the Chronically Sick and Disabled Persons Act 1991 (as amended) and, if not, the reasons why such an assessment has not been carried out and whether it is proposed to carry out such an assessment;

    i) if there has been such an assessment, what needs or requirements have been identified and how those needs or requirements will be met;

    j) if the patient is subject to or has been the subject of a Care Order or an Interim Care Order:

    - the date and duration of any such order;

    - the identity of any person(s) with whom parental responsibility is shared;

    - whether there are any proceedings which have yet to conclude and, if so, the court in which proceedings are taking place and the date of the next hearing;

    - whether there has been any liaison between, on the one hand, social workers responsible for mental health services to children and adolescents and, on the other hand, those responsible for such services to adults;

    - the name and contact details of the social worker who is discharging the function of the Nearest Relative under 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 and Young Persons Act or the Family Law Act 1991 or their equivalents in any part of the British Isles 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 and Young Persons Act or the Family Law Act are in existence in respect of the patient and, if so, the details of those orders, together with the date on which such orders were made, and whether they are final or interim orders;

n) if a patient has been or is a looked after child under Section 20 of the Children and Young Persons Act, when the child became looked after, why the child became looked after, what steps have been taken to discharge any obligations authority under the Children and Young Persons Act.

o) if a patient has been treated as a child in need (which includes a child who has a mental disorder) under the Children and Young Persons Act, 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 the Children and Young Persons Act, the date on which the order was made, the reasons it was made, and the date it expired; and

q) if a patient is a child provided with accommodation under the Children and Young Persons Act, what steps have been taken to discharge notification responsibilities, and related obligations under the Children and Young Persons Act.

E. PREPARATION OF HEARING BUNDLES

23. The Department or the Senior (or such other social worker as the Department shall designate) Social Worker shall liaise with the clerk to the Tribunal and the Tribunal office in the production of the master bundle for any hearing.

24. The bundle must be sequentially paginated on every page.

25. It must include, in the following order, copies of:

- The appeal or application.
- All papers and forms completed relating to the admission of the patient into hospital under the Act.
- The Statement of Information.
- The Responsible Clinician's Report.
- The Nursing Report.
- The Social Circumstances Report.
- Reports that are relevant from other agencies.
- Copies of relevant correspondence, documents, Orders.

26. In the case of any previous Tribunal hearing on the Isle of Man in the last 3 years, for each hearing, separately, copies of:

- The appeal or application.
- All papers and forms completed relating to the admission of the patient into hospital under the Act.
- The Statement of Information.
- The Responsible Clinician's Report.
- The Nursing Report.
- The Social Circumstances Report.
- Reports that are relevant from other agencies.
- Copies of relevant correspondence, documents, Orders.