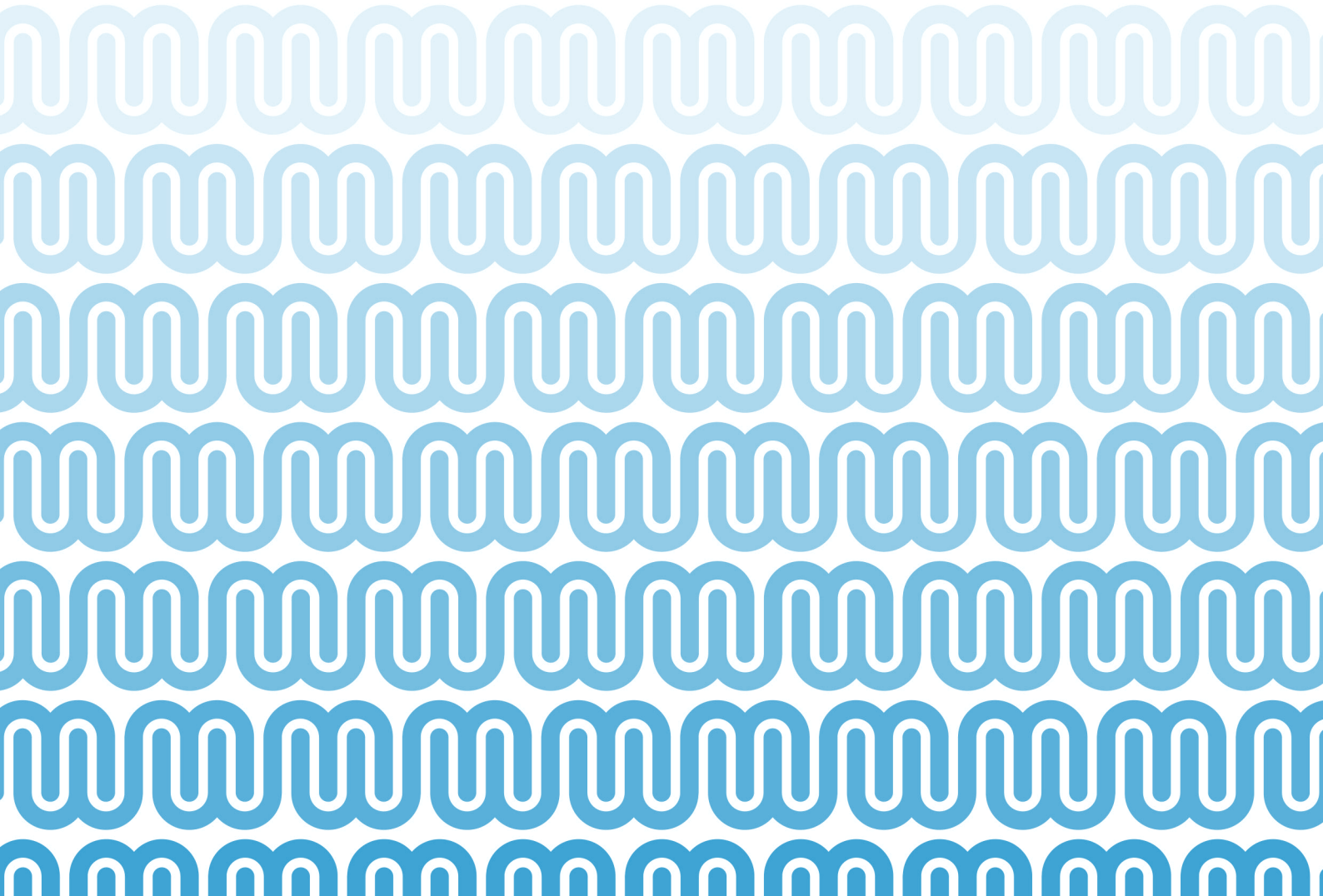
mental welfare commission for scotland

Survey of recorded matters made under the Mental Health Act

Statistical monitoring

October 2023



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Commission's placement scheme for higher trainees in psychiatry

The Mental Welfare Commission hosts a training placement for higher trainees in psychiatry in their final year of training before being eligible for consultant psychiatrist roles. As part of their placement trainees are encouraged to work on a project of their interest that aligns with the priorities of the Commission. This report arises from the work of a trainee on placement, supported by Commission staff.

Contents

Executive summary

Recorded matters (s64, the Mental Health (Care and Treatment) (Scotland) Act 2003) are an important safeguard of human rights.

Our last two surveys on recorded matters in 2009[1] and 2013[2] reported that recorded matters, when made, were often vague and did not focus on essential aspects of care and treatment. The 2009 survey showed that a recorded matter had been complied with in only 22% of cases and that there were no notifications of failure to comply with a recorded matter (CTO10 form) within the period reviewed.[1]

The present survey aimed to review the numbers of recorded matters made between 2019 and 2022, with a view to comparing data with previous surveys and to explore whether the COVID-19 pandemic had an impact on recorded matters made.

Our results suggest that whilst the number of recorded matters made does not appear to have been significantly impacted by the pandemic, looking longitudinally over the last 17 years, the numbers have decreased.

In 2006, 14.8% of Compulsory Treatment Order (CTO) cases specified recorded matter(s), compared to 2.4% in 2022.

Recorded matters provide a mechanism to realise the principle of reciprocity within the Mental Health Act, and can encourage service improvement and development. Our survey shows considerable progress compared to the prior surveys, in terms of specifying timescales for delivery of recorded matters and the number of references made to report non-provision. However, we note that the percentage of cases where recorded matters are made has decreased over time.

There may be scope for recorded matters to be used more to realise the principle of reciprocity, prevent prolongation of detention, and focus on unmet care and treatment needs.

Introduction and aims

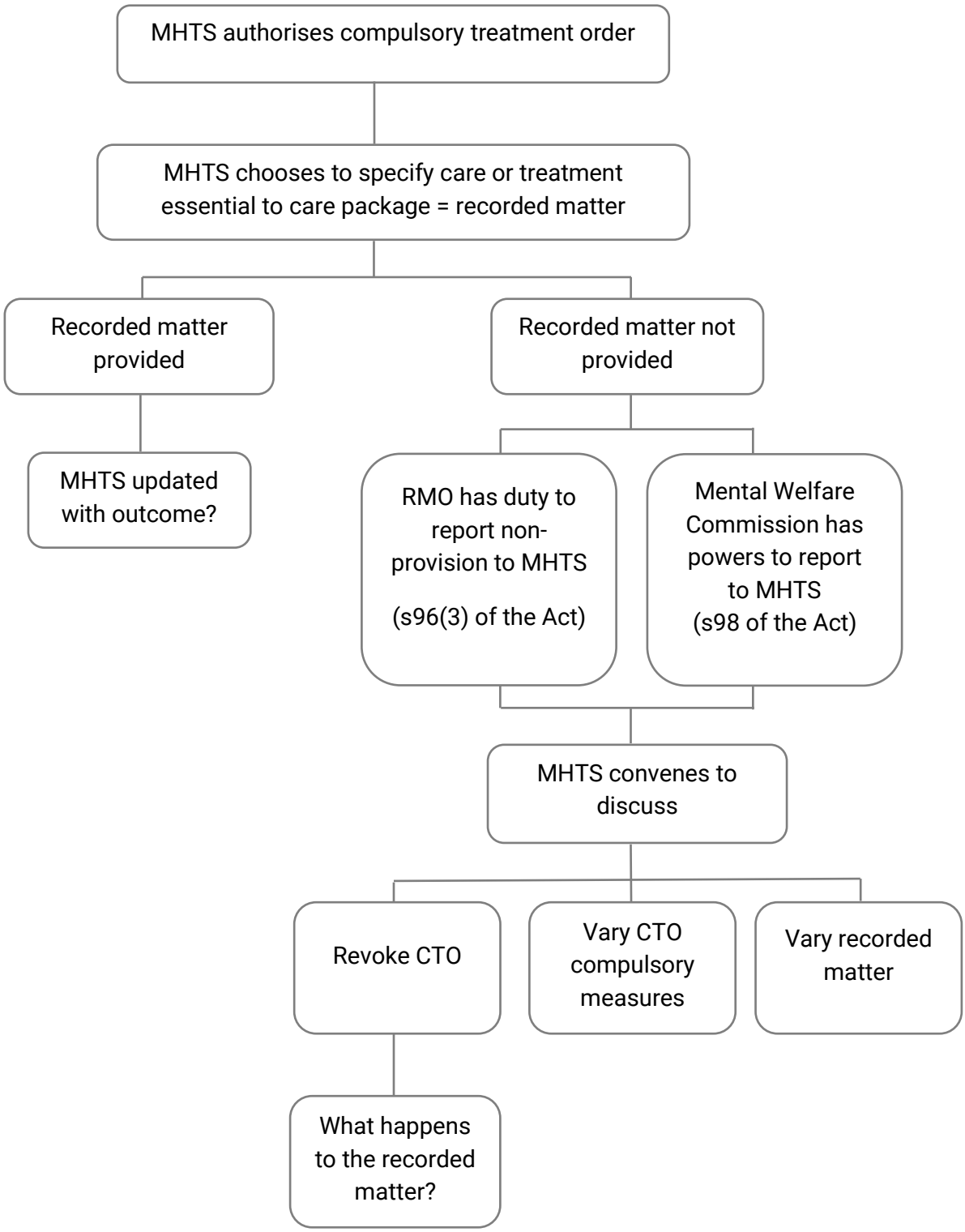
The Mental Welfare Commission is a statutory independent organisation that safeguards the rights of people with mental illness, learning disability, personality disorder, dementia, and associated conditions. We have duties to monitor the Mental Health Act, and, in that capacity, the Commission has previously conducted surveys to understand how recorded matters are working. The aim of the current survey was to provide an updated review on the use, themes, and outcomes of recorded matters between 2019 and 2022, as the last the Commission survey was completed 10 years ago. We also aimed to review the total numbers of recorded matters and compulsory treatment orders as recorded on our systems since 2006, to include the time frame reviewed in the last two surveys[1,2]. Finally, we looked to explore whether the COVID-19 pandemic had any impact on recorded matters made during that time.

Background

When granting an application for a person to be detained under a compulsory treatment order (CTO), the Mental Health Tribunal for Scotland (MHTS) may make a "recorded matter". Section 64 of the Mental Health Act, defines a recorded matter to be "medical treatment, community care services, relevant services, other treatment, care or service as the Tribunal considers appropriate." Further guidance in the Mental Health Act Code of Practice[3] notes that in the making of such recorded matters the MHTS considers these aspects of care and treatment to be "essential to the care package."

If a recorded matter is not provided, the responsible medical officer (RMO) must make a reference to the MHTS, via s96 of the Mental Health Act. Under s98, the Commission has the power to report the non-provision of the recorded matter, which can be reviewed by the MHTS to consider next steps (figure 1).

Figure 1: recorded matter process



2009 survey

The Commission's first survey of recorded matters in 2009 found that the number of recorded matters being made was declining over the 3-year period analysed (October 2005 to December 2008). Approximately half of all recorded matters made during that time were classified by the authors of the survey as "inappropriate" (by which they meant that treatments that they deemed were not essential were recommended, or the matters were non-specific or had impractical timescales for provision, or that there was a non-availability of service), and only 20% of the remaining were specific in treatment, care, and timescales for completion. There were no notifications of failures to comply with the recorded matter via s96 or s98 of the Act. The most common themes of recorded matters were psychology (9%) and community care needs assessments (7.3%). The survey led to recommendations for better training and guidance for MHTS, information sharing about recorded matters with those involved in a person's care and improved follow up where a recorded matter is made. In addition, it was proposed that consideration be given towards allowing MHTS to undertake forceful direction when a recorded matter is not provided.

2013 survey

The subsequent survey in 2013[2] repeated the initial data collection for recorded matters made between January 2011 and October 2013. It showed that the number of recorded matters made fell to one-third of those made in the 2009 survey. The survey included a qualitative aspect with a questionnaire to RMOs, mental health officers (MHOs), patients and named persons. This explored the appropriateness and specificity of recorded matters and what effect they had on a person's care and treatment. Whilst it noted some improvements since the initial survey, there was still evidence of poor utilisation and compliance with the recorded matter. Timescales continued to be vague, only 67% of cases sent a report to update the MHTS on outcomes and only 10% of cases had a reference made under s96 by the RMO. In 37% of cases, the authors did not note an explanation from the MHTS as to the reasons for making the recorded matter. Responses to questionnaires from service users and named persons highlighted that they did not have a good understanding of recorded matters and some patients did not even know a recorded matter had been made. This reflected a shortcoming in application of the 'participation' principle of the Act. However, the 2013 survey showed that overall, recorded matters were perceived to make "a real difference to service users."

The outcome of both surveys showed that recorded matters are an important safeguard, but the Commission considered that they were neither being utilised appropriately nor to their full potential. The surveys concluded that further work was required to improve people's understanding of recorded matters and that MHTS training would help to improve utility of this safeguard.

Method

For this data-based project, an initial search of the Mental Welfare Commission database (Information Management Portal) which holds all the relevant records for people subject to the Mental Health Act, was carried out to identify cases where recorded matters were made between 2019-2022.

We reviewed Mental Health Act paperwork, including applications for CTO (form CTO1), applications to vary, extend or review the determination to extend a detention (forms CTO5, CTO3b and CTO4) and notifications of failure to comply with a recorded matter (form CTO10). The Tribunal Full Findings and Reasons documents (FFRs) and any correspondence with the Commission was also reviewed. This is similar to the methods used in the prior two surveys.

In addition, this survey also included data from REV4 forms (determination of an appeal to revoke or vary a detention) as this is another mechanism through which the Commission might be informed of a recorded matter.

The following information was extracted from the above sources:

- demographic data on gender, age, and ethnicity
- the subject of recorded matters made and whether timescales for completion were specified
- whether designated persons responsible for ensuring delivery of the recorded matter were specified
- notifications of failure to comply with the recorded matter (CTO10)
- postcode data to ascertain any relationship between recorded matters made and deprivation scores

As in the previous surveys, we categorised the themes of recorded matters in line with the terminology used in s64 of the Act on what aspects of care and treatment could be made a recorded matter. However, the 2009 survey also included the category "not appropriate" recorded matters. We have not used this category as we did not consider that we could be in the position to understand all the relevant details that might have been available to the Tribunal members at the time. The categories for the current survey were therefore as follows:

1. "Medical treatment" (defined in s329 of the Act)[3] which includes "nursing, care, psychological intervention, habilitation (including education, and training in work, social and independent living skills) and rehabilitation"
2. "Community care services" – interpreted as community placement, care packages, allocation of social worker
3. "Relevant services" this follows the meaning from s20(2) of the Children (Scotland) Act 1995
4. "Other treatment, care or services"

Results

The previous two surveys of recorded matters did not include data from REV4 forms. The additional numbers of recorded matters (RM) from these forms between 2019-2022 are shown below. This allows comparison with previous surveys and also allows this survey to be more comprehensive. We present the data on the numbers of recorded matters against the numbers of CTOs (expressed as a percentage of the latter) to aid with consideration of what the reduction in numbers means in terms of a proportions of CTOs in which a recorded matter is made.

Table 1. numbers of recorded matters against the numbers of CTOs

	2019	**2020**	**2021**	**2022**
Number of cases where RM made (excluding REV4 forms)	46	38	30	30
Number of cases where RM made (including REV4 forms)	59	42	42	39
Total number of RMs excluding REV4 forms	50	50	37	32
Total number of RMs including REV4 forms	65	55	55	45
Total number of CTOs	1506	1580	1634	1659
% cases where RMs made (including REV4 forms) of total CTOs (comparison figures excluding REV4 forms in brackets)	**3.9%** (3%)	**2.7%** (2.4%)	**2.6%** (1.8%)	**2.4%** (1.8%)

Between 2019 and 2022, there were 189 cases where recorded matters were made by MHTS, which equates to 2.9% of all CTOs during this period. 19.6% of cases had more than one recorded matter in the years 2019-2022, making the overall number of separate recorded matters made during this period 220.

There has been a continued decline in numbers of recorded matters made over the years.

The total number of cases where recorded matters were made in 2022 was 22% of the number made in 2006 (figure 2a).

During the timeframe we reviewed, the number of cases where recorded matters were made decreased by 34% from 59 cases in 2019 to 39 cases in 2022.

Figure 2a: recorded matters 2006-2022 (including data from REV4 forms)

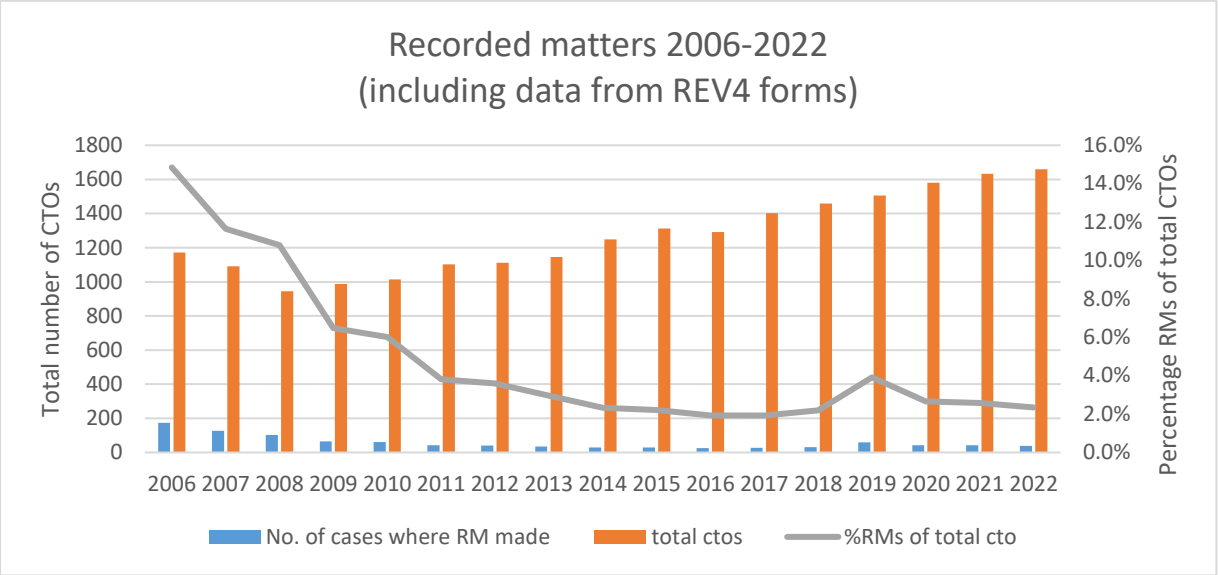
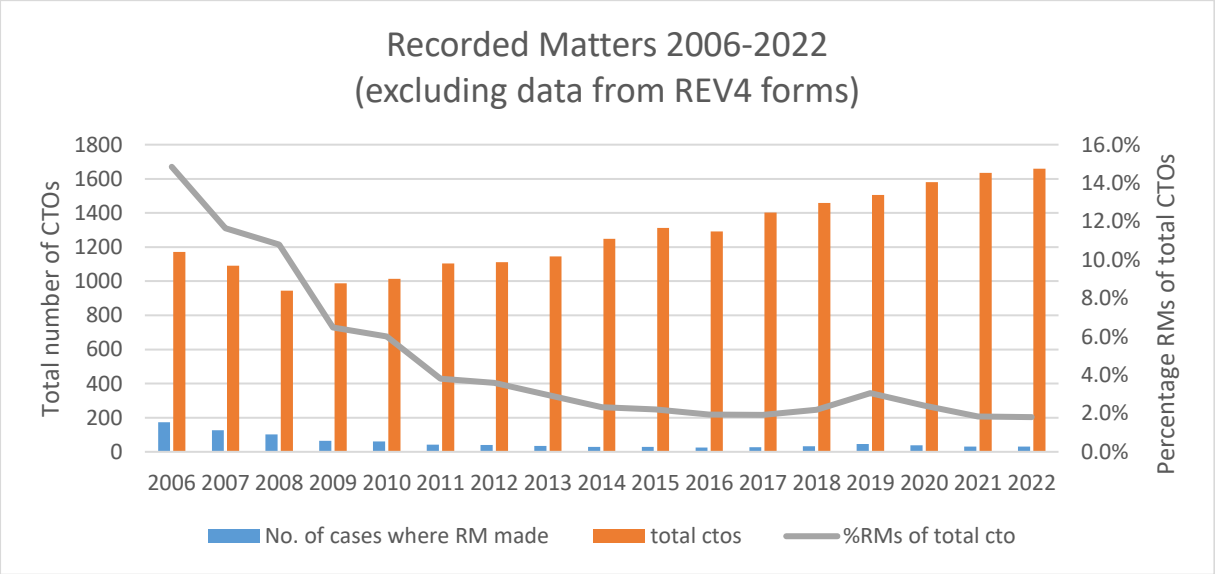


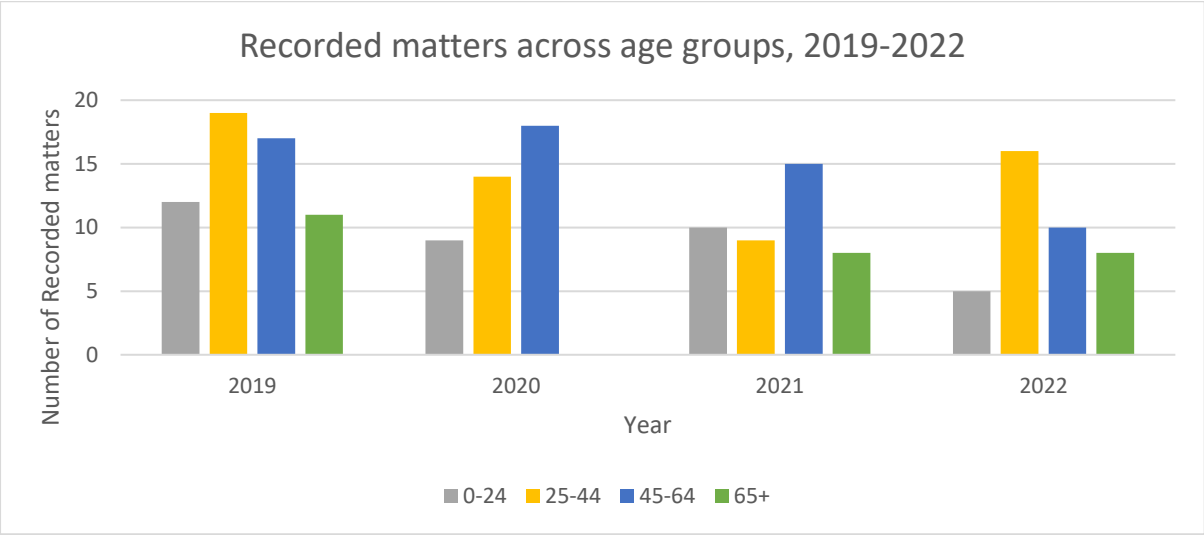
Figure 2b: recorded matters 2006-2022 (excluding data from REV4 forms)



Demographics

For the age group over 65 years, despite accounting for 31% of all people detained under CTO in 2020, only 2% of cases where recorded matters were made were for this age group. Whereas in the other three years reviewed, this age group consistently made up approximately 30% of all CTOs each year, whilst concurrently accounting for approximately 20% of recorded matters made each year (figure 3).

Figure 3: recorded matters across age groups, 2019-2022



When comparing the proportion of CTOs by gender and the proportion of recorded matters made by gender, we found that whilst similar numbers of males and females were detained under CTOs in 2020, a greater proportion of males had recorded matters made. The number of recorded matters made for males in 2020 was almost double the number made for females in 2020 (figures 4a & 4b).

Figure 4a: proportion of CTOs and recorded matters in males

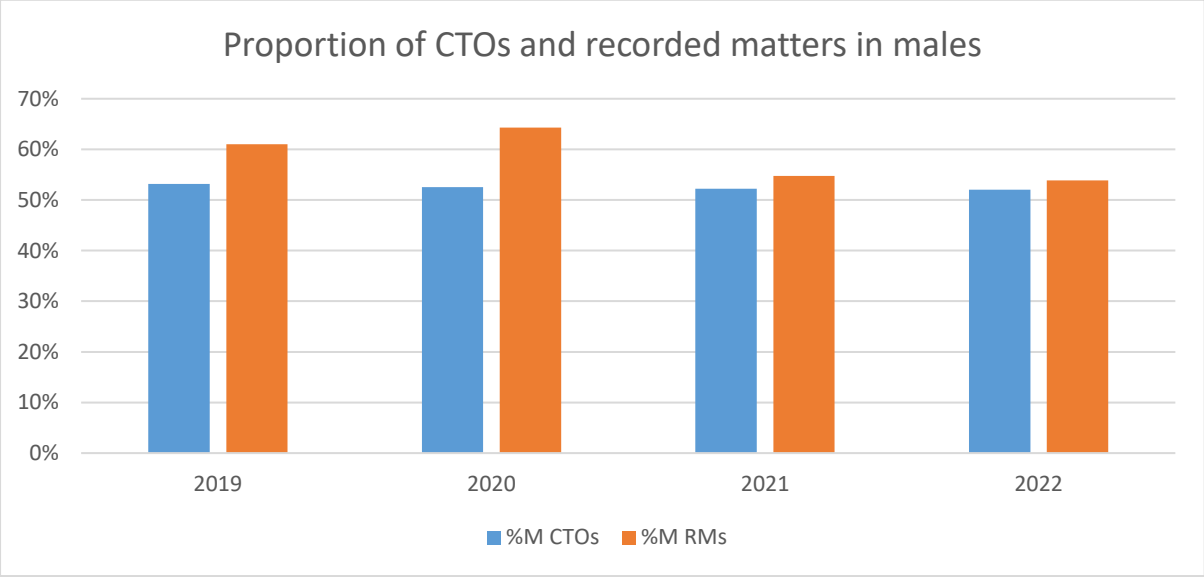
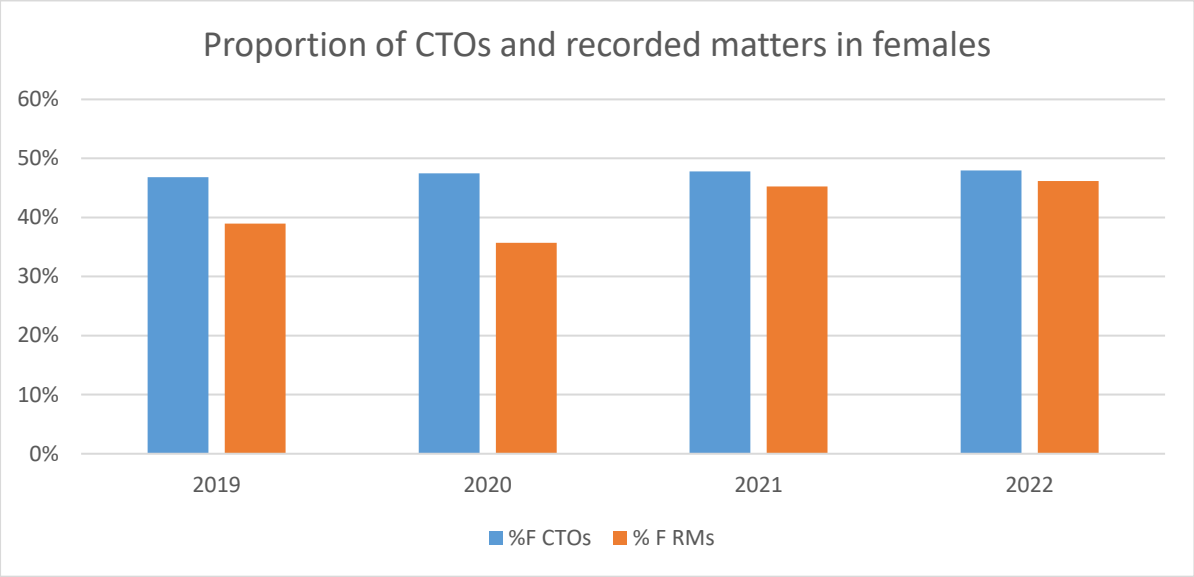


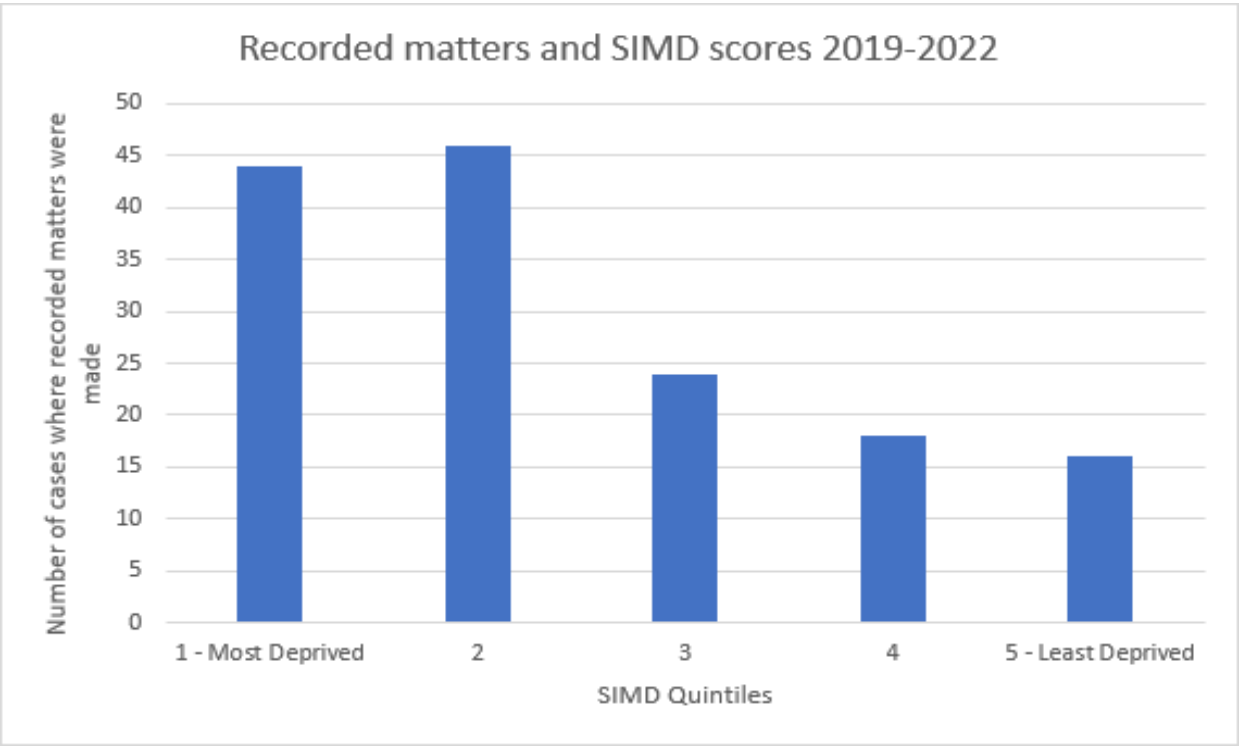
Figure 4b: proportion of CTOs and recorded matters in females



In terms of ethnicity, we found that whilst people of African, Caribbean, or Black ethnicity made up 1-2% of all people detained under CTO over the 4-year period, no recorded matters were made for this ethnicity group between 2019 and 2021. In 2022 the proportion of recorded matters made for this ethnic group was 2.6%.

Using the Scottish Index of Multiple Deprivation (SIMD) tool and postcode data available from 148 cases, we found that over the four years, 61% of recorded matters were made for those living in the more deprived areas of Scotland (SIMD quintiles 1 and 2) (figure 5).

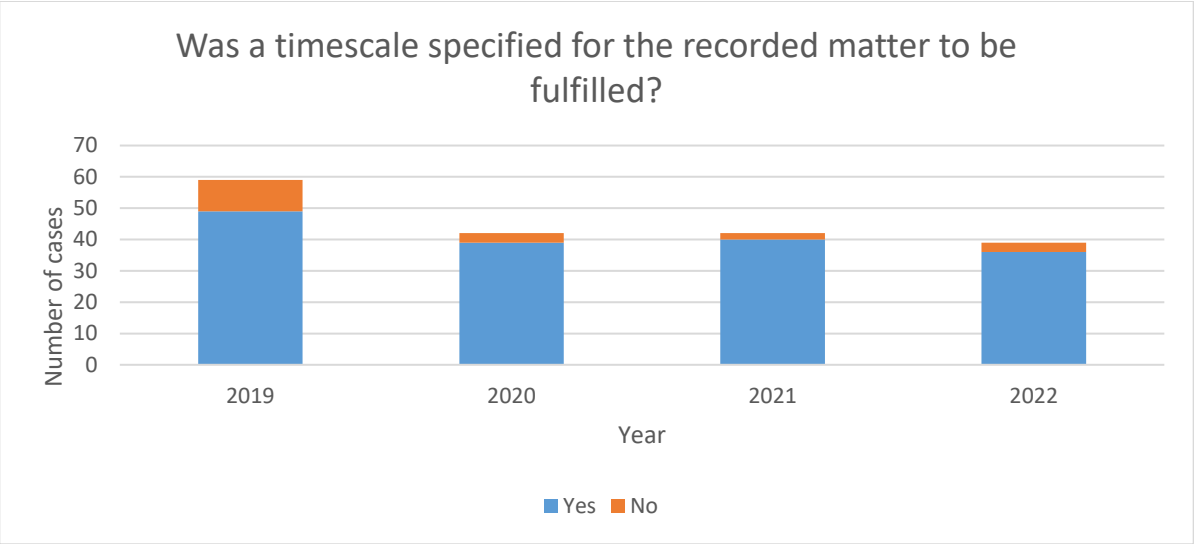
Figure 5: recorded matters and SIMD scores 2019-2022



Making of a recorded matter and reporting of non-provision

Most recorded matters specified a timescale for completion. In 2019, the proportion of recorded matters cases where no timescale was specified was 17%. It was 5% in 2021 and 8% in 2022 (figure 6). This is a marked difference since the 2009 survey which reported that 80% of cases had no timescale, that is, only 20% of cases directed care or treatment within a timescale.

Figure 6: was a timescale specified for the recorded matter to be fulfilled?



Whilst prior surveys commented on "appropriateness" of a recorded matter, we chose not to do this in the present survey as the methodology did not include any qualitative aspects. We also note that there is no clear definition of what constitutes 'appropriateness' of a recorded matter.

Instead, where we could not clearly categorise recorded matters into either (1) medical treatment, (2) community care or (3) relevant services, we placed them in (4) other treatment, care, or services.

There were 19 recorded matters over the 4-year period which we classified in category 4. The most common themes of recorded matters were "medical treatment" and "community care services" which accounted for 84-91% of all recorded matters made between 2019-2022 (figure 7). Examples of recorded matters for each category are noted below:

1. **Medical treatment**
   "(RMO) to secure psychological therapy as soon as possible"

2. **Community care services**
   "(MHO) to produce a home-based care plan within 3 months, identifying a care package with appropriate level of care, potential care providers and funding to applied for and established"

3. **Relevant services**
   "(RMO) to instruct Autism specialist to advise on patient's environment, care, and clinical management within 8 weeks"

4. **Other treatment, care, or services**

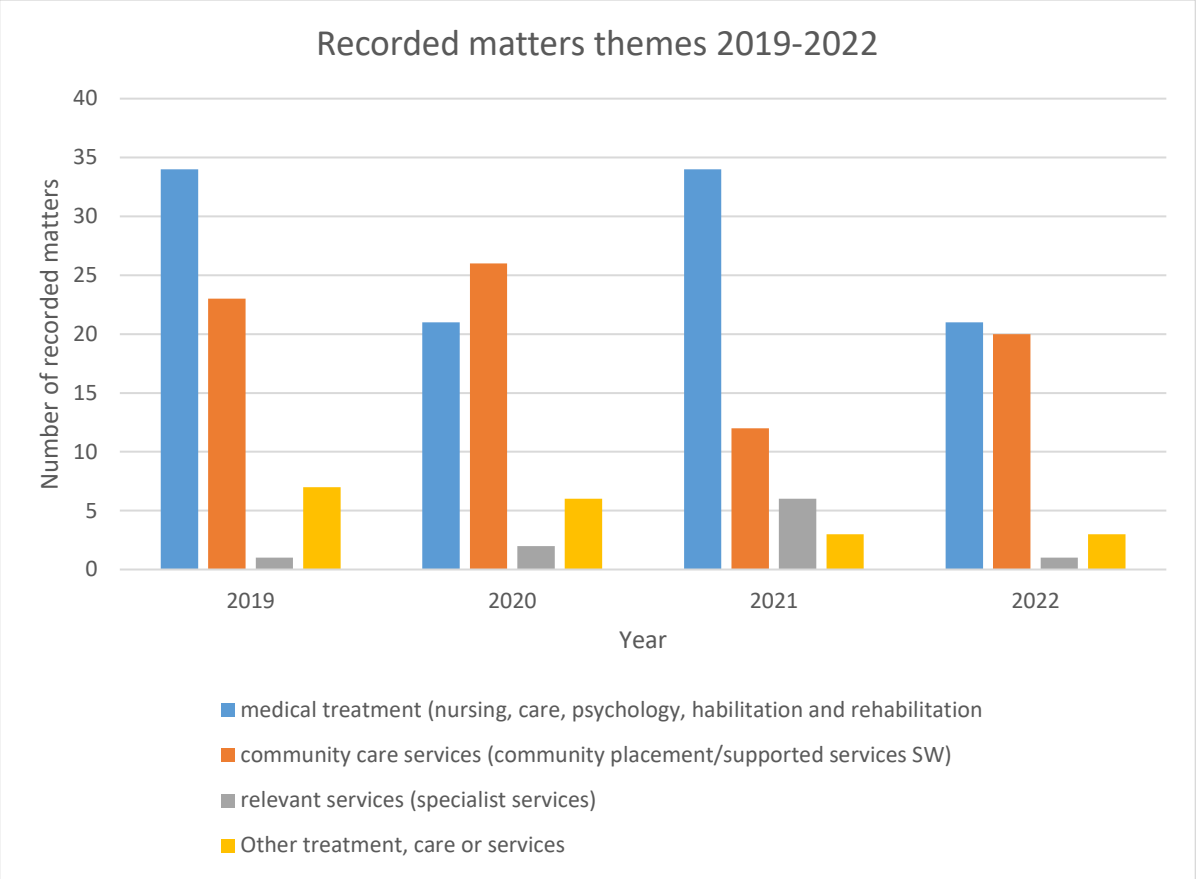
"…to provide a report on the progress being made on the project to provide the patient with new-build accommodation and support no later than 12 months from this order"

"…chief social worker to take necessary steps to have fire alarm fitted…"

"Patient to be transferred from IPCU to an open ward asap. Noted [patient] is first on the list for a bed there"

"Tribunal request that the (RMO) continue to pursue step down service options for hospital-based care"

Figure 7: recorded matters themes 2019-2022



Over the four-year period, 35% of cases specified the RMO as responsible for ensuring delivery of the recorded matter, 21% of cases did not specify a designated responsible person, 14% allocated the MHO and 10% allocated social work responsibility for ensuring provision of the recorded matter.

In contrast to previous surveys, there were more references made to the MHTS to report non-provision of a recorded matter (CTO10s). Between 2019 and 2022, there were 41 CTO10s completed, with yearly numbers between 2019-2021 ranging from 11-14, however falling to less than 5 in 2022.

What this means

The data shows that there has been a steady decline in the number of cases where recorded matters are made since 2006, with numbers reaching an all-time low of 1.9% of CTOs in 2016 (figure 2a). During the timeframe we reviewed, there was a 34% decrease in numbers of cases where recorded matters were made from 2019 to 2022.

Interestingly, there was only a 1.2% drop in the number of cases where recorded matters were made between 2019 and 2020. The COVID-19 pandemic may have influenced decision making around what recorded matters were made for example, we found that over the four years, 2020 was the only year where the number of recorded matters made relating to community care services was greater than the number relating to medical treatment (figure 7).

During the phase of data collection for this survey, we noted that reporting on outcomes of recorded matters continues to be poor. There was little clarity from our review on whether the recorded matter had been met, or deemed no longer necessary, or had not been provided, particularly in the cases where the CTO was revoked where there is no mechanism to report on the provision or not of the said recorded matter. Whilst some may argue that if a CTO has been revoked the recorded matter serves no purpose, due consideration ought to be given to a matter deemed essential by the MHTS to the individual's care and treatment that may be pertinent to maintaining well-being and in preventing further episodes of compulsion. In some instances, it may be necessary to continue to work to provide the recorded matter despite revocation of the CTO, as also proposed in the Scottish Mental Health Law Review (2022) (SMHLR)[4].

Whilst reporting of non-provision of a recorded matter has improved markedly since the last two surveys on recorded matters, there were instances where making a reference to the MHTS appeared to have little consequence, which may in part be due to lack of enforceability. MHTS will always arrange a hearing when a reference is made on the non-provision of a recorded matter. We note with interest the recommendation from the SMHLR relating to an enforceable duty on NHS boards and local authorities to comply with a recorded matter[4].

Over the four-year period, we found cases where the same recorded matters continued to be unmet for several years (pre-dating the period analysed). These cases involved repeated references to the MHTS via s96 and the same or similar recorded matter(s) being restated following the tribunal hearing. Whilst such examples highlight that there is a gap in services for particularly complex cases requiring more health and social care input and specialised services, we wondered about the utility in revising a recorded matter over multiple consecutive years, only to be no closer to achieving the desired outcome for the individual. In such instances, what more could be done and more so, if the service desired is not available, should the recorded matter continue to be made?

It has now been 10 years since the last survey on recorded matters. Since then, there has been a renewed attention to human rights legislation, with the SMHLR recommending a human rights-based approach to mental health care and treatment. The SMHLR recommends "minimum core obligations" for economic, social, and cultural rights for people with mental or intellectual disability (recommendation 6.8 SMHLR)[4]. Economic, social, and cultural rights include rights to food, water, housing, health, education, work, social security, cultural identity,

and healthy environment[5]. The provision of recorded matters is an important safeguard which could help in operationalising these economic, social, and cultural rights.

Considering a broader human rights framework which encompasses economic, social, and cultural rights will be useful in thinking holistically about people's care and treatment needs and what might constitute a recorded matter. Additionally, considering existing guidance for example, from Scottish Intercollegiate Guidelines Network (SIGN) or National Institute for Health and Care Excellence (NICE) when making a recorded matter, may help provide better focus in terms of what aspects of care and treatment should be made a recorded matter. The broadening of scope and evidence-based approach to treatment/service aspects that ought to be available may also help the requirement around enforceability (as recommended by SMHLR) to be better realised.

Finally, although beyond the scope of this survey, we note Lord Harrower's opinion[6] that the absence of powers for the Tribunal to specify recorded matters in relation to compulsion orders represents a difference in treatment of forensic and civil patients, which is discriminatory and in breach of Article 14 of the European Convention on Human Rights. The SMHLR also recommends extending recorded matters to those subject to forensic orders.

Conclusion

In conclusion, we note that the percentage of cases where recorded matters are made has decreased over time. There may be scope for recorded matters to be used more to realise the principle of reciprocity and focus more holistically on people's care and treatment needs, whilst highlighting areas for service development.

The Commission will use the information contained in this report to inform discussion and collaboration with NHS Education for Scotland, Mental Health Officer training programmes, Mental Health Tribunal for Scotland, and Scottish Government.

Acknowledgement

This work was led by Dr Neha Bansal, ST6 in Psychiatry of Intellectual Disabilities, as a higher trainee on placement at the Mental Welfare Commission

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