

# Social Circumstances Reports

Good practice  
guidance on the  
preparation of Social  
Circumstances Reports  
for mental health  
officers and managers



## Who we are

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- be treated with dignity and respect;
- have the right to treatment that is allowed by law and fully meets professional standards;
- have the right to live free from abuse, neglect or discrimination;
- get the care and treatment that best suits his or her needs; and
- be enabled to lead as fulfilling a life as possible.

## What we do

- We find out whether individual treatment is in line with the law and practices that we know work well.
- We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice, information and guidance to people who use or provide mental health and learning disability services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

### Background to this guidance

The Mental Health (Care and Treatment) (Scotland) Act 2003 introduced significant changes relating to the statutory provision of Social Circumstances Reports (SCRs). The Mental Welfare Commission welcomed these changes, which have resulted in an increase of over 50% in the provision of SCRs compared to the number provided under the 1984 Act. While we have commented favourably on the response of Mental Health Officers (MHOs) in providing more SCRs, as well as on the quality of these reports, we still have some concerns relating to SCR provision. Central to these concerns is the lack of a strategic approach among most local authorities to assist MHOs in determining when an SCR should be provided. MHOs need a framework to assist them when using their discretion about whether or not an SCR is produced.

In our Annual Report of 2006-2007 we stated that, “We expect that local authorities will audit their own practice in this area and that managers of MHO services support frontline MHOs to decide which reports are necessary and which would serve little purpose. This is in line with the MHO standards published by the Scottish Executive in 2006”.

We have identified this area of practice as one where practitioners and managers continue to have difficulty in achieving consistency in the circumstances in which service users, Responsible Medical Officers (RMOs) and the Mental Welfare Commission could expect a report to be prepared.

We have therefore consulted relevant stakeholders and produced guidance on best practice that aims to be of use to practitioners and managers when considering the preparation of a Social Circumstances Report. This guidance may also be of interest to service users, carers, RMOs and advocates.

## 1. Social Circumstances Reports in context

### Introduction

The implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) further extended the duties and responsibilities of mental health officers (MHOs) and confirmed this specialist social work role as a local authority function.

One of the duties required of an MHO is to produce a Social Circumstances Report (SCR) under section 231 of the 2003 Act. An MHO is regarded as having expertise in analysing the interaction between the health and social circumstances of the person who has been detained, together with the knowledge of alternative care and support options which may be available in the community.

Despite the content of an SCR being clearly set out in the Mental Health (Social Circumstances Reports) (Scotland) Regulations 2005 and their purpose in the Code of Practice (Volume 1 Chapter 11), there continues to be a lack of understanding of these issues in practice. This is highlighted in contributions made to the *Newsletter for Mental Health Officers in Scotland* (Issues 14 and 15). The newsletters provided differing practitioner opinions in relation to the purpose of SCRs and in the context of the other legislative demands placed on MHOs. One question posed was ‘What’s the point of an SCR?’

The 2003 Act defines the ‘relevant events’ (section 232(1)) that trigger the requirement for an MHO to prepare an SCR for the patient’s Responsible Medical Officer (RMO) and the Mental Welfare Commission. An MHO need not comply with this requirement

where s/he considers that preparing an SCR “would serve little, or no, practical purpose”. Where this is believed to be the case the MHO must record the reasons and send this record to the patient’s RMO and us. We believe that the intention here was to allow the flexibility to direct MHO resources to those situations where it is felt they are most needed, while at the same time affording MHO managers and ourselves the opportunity to monitor how the provision of SCRs is being prioritised in any given area. It also allows for RMOs and the Commission to argue that they would find a report helpful, where an SCR is not provided. Unfortunately, the under-reporting of the reasons for not providing an SCR, following a relevant event, undermines the intention of the Act.

There is guidance in the Code of Practice (Volume 1) in relation to the type of circumstances which might lead the MHO to decide that an SCR might serve ‘little, or no practical purpose’ (section 231(2)). However, in the context of extended MHO duties, confusion over when to provide reports and the questioning on the part of some MHOs as to their purpose, we felt that best practice advice to complement the Code of Practice would be helpful to practitioners and managers. This guidance aims to help enhance the quality of reports and achieve greater consistency in the circumstances in which we, service users, and RMOs could expect to see an SCR.

### Legislative basis

SCRs are not new pieces of work for MHOs. The Mental Health (Scotland) Act 1984 directed MHOs to provide SCRs where there was no MHO consent to short-term detention. SCRs prepared where MHO consent was given to short-term detentions (S.26) were not statutorily required, but were regarded as good practice. Under the 1984 Act, short-term detentions required the consent of either a nearest relative or an MHO wherever practicable. Many relatives found this difficult, as it could affect their relationship with their relative. MHOs often relieved the nearest relative of the responsibility of consenting to short-term detentions. The majority of SCRs provided were done on the basis of this good practice, rather than statutory requirement. In saying this, the majority of people detained on a short-term basis never received an SCR. Managers of MHO services were never able to say with any authority under what circumstances an SCR would, or would not, be provided in their area. It was clear that the decision rested with individual MHOs or individual team managers. Strategic approaches to the provision of these reports were rarely, if ever, apparent.

The 2003 Act defines relevant events as:

- The granting of a short-term detention certificate (S44(1))
- The making of an interim-compulsory treatment order (S65(2))
- The making of a compulsory treatment order (S64(4))
- The making of an assessment order (S52D CPSA)
- The making of a treatment order (S52M CPSA)
- The making of an interim compulsion order (S53 CPSA)
- The making of a compulsion order (S57A CPSA)
- The making of a hospital direction (S59A CPSA)
- The making of a transfer for treatment direction (S136).

This list would suggest that a patient who is detained according to a short-term detention certificate, then an interim-compulsory treatment order and finally a compulsory treatment order, would require three SCRs within an approximate three-month period. This is clearly unnecessarily burdensome to some practitioners and would not yield significant new information about the individual. As such, the requirement only serves to undermine compliance with the Act. We have suggested to the Mental Health Act Review Group that the wording in Section 232 is changed; so that only one SCR is required in relation to a single relevant event, or a series of consecutive relevant events.

Whilst we question the value of three SCR in such a limited time span, there are still many other situations where an SCR is not provided and no SCR 1 form is completed stating the reasons for this. This is because MHOs only prepare SCR following a minority of relevant events. Unfortunately, because the SCR 1 (the form to be used when an SCR is required under section 231) is most often not completed when an SCR is not being provided, we can't determine on what basis that decision has been made. We therefore find it difficult to see how MHO service managers can determine whether this valued resource is being used effectively.

### The purpose of an SCR

The Mental Health Act 2003: Code of Practice (Volume 1) highlights the importance of SCR to RMOs in relation to assessment, participation of relevant others and future care planning. The purpose of the 21 day timescale for completion of an SCR (after a relevant event) is to ensure the MHO's assessment and details of the individual's social circumstances are considered when deciding whether further care and treatment on a compulsory basis is required.

The Commission has a duty under part 2 of the Act to monitor the operation of the Act and to promote best practice in relation to its operation. We also have responsibility to investigate unlawful detention; ill-treatment; neglect; deficiency in care or treatment; loss or damage to property as a result of a person's mental disorder; and, to investigate a person's situation where he lives alone and is unable to look after himself, his property or financial affairs. SCR provide us with details of individual circumstances leading

to detention (and/or other measures of compulsion) and alert us to any impropriety in relation to the detention. They also identify matters which fall within our remit, that we might want to investigate further.

Our practitioners routinely read SCR and – if an MHO directs us in a covering letter – we will read them as soon as we receive them.

The SCR is an extremely important document which should examine the interaction of an individual's social and family circumstances with their mental disorder. It will comment on issues that the MHO feels will need to be addressed when planning care and treatment. It gives the MHO an opportunity to secure vital information from carers, who may play a crucial role in the future care and support of the individual. It is also an opportunity to offer information and support to carers. The possible need (or not) of compulsory measures to underpin future care and treatment should also be examined. The SCR will also examine which compulsory measures, if any, will underpin the person's future care and treatment.

In addition, the SCR will help to paint a more rounded picture of the person as a unique individual. The MHO's use of their specialist social work skills in the creation of a good SCR lends itself well to the recovery approach. It is an opportunity for the MHO to assist the individual in taking control and using their strengths and available supports in the recovery process. These inherent strengths and supports should be identified wherever possible in SCR.

The SCR should not be viewed as an end in itself, but as part of an ongoing process of working with an individual, their carers and the multidisciplinary team to assist the recovery of the individual. It is also an excellent opportunity for MHOs to apply their specialist professional skills in working with the individual. An SCR will record and impart crucial information and will aid communication with the multidisciplinary team. It is not, however, a substitute for direct, personal input from the MHO.

People who are subject to compulsory measures have, by definition, complex individual needs and the process of compiling the report provides the MHO with an informed position from which to make decisions, whether in relation to civil orders, or orders made under criminal proceedings.

## 2. Current practice picture: some of the reasons given for Social Circumstances Reports not being prepared

### Mental Welfare Commission Annual Reports

We report annually on the level of SCR provision across Scotland. Recent reports have shown an increase in the number of SCRs written since 5th October 2005. SCR provision has increased by 50% since the 2003 Act was implemented.

This increase, however, falls far short of the number of relevant events which have occurred under the 2003 Act. Excluding interim orders, the total number of relevant events for 2007-2008 was 4,570. As a result of these, 1,583 SCRs were prepared Scotland-wide and 521 notifications were received to say that an SCR would 'serve little or no practical purpose'. There were 2,466 relevant events where we (and the RMO) received no SCR, or notification that one was not being prepared. Along with RMOs and MHO service managers, we therefore have no information as to why a significant majority of SCRs were not compiled.

### Our review of notifications

In a sample of 100 SCR 1 notifications, where it was felt the provision of an SCR would serve 'little or no practical purpose', MHOs recorded a number of reasons for their decision (see table on page 7).

Reason for no SCR	Number
Short-term detention revoked	24
Earlier SCR available (not relating to current detention period)	16
Well known to services	15
SCR completed at an earlier stage of the current detention process	13
Too busy: workload pressures	10
CTO application in progress	9
RMO opinion	3
Engagement	3
Designated MHO on annual leave	2
No reason given	2
Not progressing to CTO	2
Complex case	1

### **The short-term detention was revoked**

Analysis of this category highlighted cases where an SCR was not completed because the order was revoked. In some cases the order was revoked within the first few days. In others, the STD had almost run its course of 28 days.

### **An earlier SCR is available**

This category refers to cases whereby an SCR exists on file from a previous detention period. In this category, many MHOs provided updated information and it could be argued that supplementary SCRs were provided in these cases. It is more accurate to say that MHOs considered the provision of a **full** SCR would serve 'little or no practical purpose' in these circumstances.

### **Individual is 'well known to services'**

This was a significant group where MHOs reasoned that, because the community care team and RMO knew the person well, an SCR would add little information to what was already held on file. This response appears to lack recognition of the value of the processes involved in preparing an SCR. It also ignores the fact that there might be information of interest and importance to us as an intended recipient of the report.

### **An SCR was completed at an earlier stage of the current detention process**

This category related to the situation whereby a person was, for example, detained on a short-term detention where an SCR was duly prepared. Subsequent SCRs for interim orders, or compulsory treatment orders (CTOs) were then thought to serve 'little or no practical purpose'. As we state above, we would see this as reasonable.

### **Too busy/workload pressures**

The Code of Practice (Volume 1) makes it clear that, "Administrative and workforce constraints alone do not absolve local authorities from this statutory duty".

The practice reality is that MHOs honestly explained on the SCR 1 that they were unable to prepare the SCR because of competing work demands. Some gave the reason that they had been too busy to prepare the report at the short-term detention stage, but would endeavour to do so following the determination of the CTO. Some went on to complete the SCR, others did not.

There were two notifications which said that the SCRs were not prepared because the designated MHO was on annual leave.

### **CTO application in progress**

Section 61(4) of the 2003 Act states that the MHO report to accompany the CTO application must include "in so far as relevant for the purposes of the application, details of the personal circumstances of the patient." This clause is in the legislation specifically to avoid extraneous, confidential, personal details being brought to the attention of the Tribunal.

The Code explains the difference between an SCR and the reports required for a CTO application. The Code of Practice points out that an SCR "may contain extraneous details which, while important historically in understanding the patient and his/her current situation, are not pertinent to the CTO application and the powers being sought." The Code further states that "there may be information on previous relationships, financial information, previous minor offences, etc. which are not seen as relevant to the application and in which it might be best to respect the patient's right to privacy and confidentiality." However, the view expressed in this group was that, as a CTO application was to be made, there was little point in preparing an SCR. The SCR was regarded as a duplication of CTO application information.

Conversely, the view was also expressed that the provision of an SCR would serve 'little or no practical purpose' because a CTO application was not being made.

## RMO opinion

In this category, MHOs asked the RMO whether s/he wanted an SCR to be prepared and the response had been 'no'. This was then cited as the reason for not providing an SCR. Considering the professional, autonomous role of the MHO, it is not clear under what circumstances such a question would be posed. This response also fails to consider the potential value of the SCR to the Commission.

## Engagement

In this category, MHOs said that it was not possible to engage the service user in the process of preparing the SCR. The Code of Practice recognises that co-operation cannot be assumed, whether this relates to the patient or relevant others. The guidance is clear an SCR should still be prepared with available information.

## Complex case

There was one example where the MHO explained that the complexities of the case were such that it was not possible to complete an SCR. We believe that this is precisely the type of case that would benefit from a process that brings together relevant information, from diverse sources, into one document.

## Consultation with practitioners

As part of the process of developing this practice guidance, we had a number of discussions with practising MHOs and managers of MHO services. These confirmed that there are a range of reasons, similar to the ones noted above, for deciding not to prepare an SCR.

It was also apparent that different cultures have developed within and between local authorities. For example, in one area practice has developed whereby SCRs are not routinely prepared for people who are already well known to services, unless the RMO specifically requests one. In another area, efforts are made to prepare an SCR for everyone after the initial relevant event if there is not a previous SCR on file. Whether or not this is achieved seems to depend on competing workload issues at the time and is apparently at the discretion of the individual MHO.

The question of the 21 day timescale for completion of the SCR was another issue raised. In some areas MHOs clearly appreciated the purpose of the SCR and its value in informing future care planning decisions, particularly following a short-term detention. There were times MHOs might not have the SCR in its final format for the 21 day time limit. It was, however, argued that SCR information would still be fed into the care-planning process within the 21 days, even if the written report itself was late. In other areas, MHOs characterised the 21 day timescale for preparing SCRs as 'arbitrary'.

The structure of the MHO service is also a relevant factor. SCRs seemed more likely to be completed where MHOs were part of a dedicated team, rather than where MHO responsibilities were carried out in addition to other social work duties.

In some cases, organisational matters limited the opportunity to allocate casework in good time. Delays in relation to communication from courts were highlighted as particularly problematic where SCRs were required for individuals involved in criminal proceedings. Local authorities should ensure protocols are in place to address such problems where they exist.

Some MHOs explained that, with experience, they had learned the important difference between the information provided within an SCR and that of a CTO report. However, the Mental Health Tribunal for Scotland's (MHTS) regular requests for copies of SCRs caused confusion and concern.

We share concerns about the MHTS receiving confidential information that is not relevant to its role. We have advised them of our concerns.

Both the 2003 Act and the Code of Practice are clear that, "Personal information should only be shared with the Tribunal in applications when such information is relevant to the application."

Knowledge and understanding of the duty to notify the Commission and the RMO where the MHO feels an SCR would serve 'little or no practical purpose' also varied across and within local authority areas. Refresher training for MHOs, local procedures and proper governance

arrangements are all needed to ensure that local authorities, their managers of MHO services and their MHOs are aware of their statutory duties and are able to carry them out as intended in the legislation. Local authorities' compliance with the National Standards for Mental Health Officer Services would greatly assist in this process.

Questions also continue to be asked about the importance we place on SCRs and whether in fact the reports are read by our officers. As mentioned previously, we regard SCRs highly and they are routinely read. An SCR is often the only element in a medical file which gives the Commission a clear understanding of the context in which compulsory measures have been used. Information in SCRs can trigger casework and investigations.

Those consulted welcomed our assessment that the quality of SCRs we receive is generally high. However, there would appear to be limited quality assurance measures adopted locally, something which should be addressed in the implementation of the National Standards for Mental Health Officer Services (Standard 7).

Informal discussion with RMOs confirmed a range of experience. This ranged from almost always receiving an SCR at the short-term detention stage, to making a joint decision with the MHO as to whether the preparation of the SCR would be useful or not, to feeling that MHOs were going out of their way to try to avoid having to compile SCRs. **All RMOs stated that a good SCR, which includes detail on social and personal circumstances, is an invaluable tool.**

It was suggested that MHOs should not assume that a patient is well known to RMOs, simply because the patient has had extended contact with psychiatric services. SCRs often include important information of which the RMO and others in the care team had not been aware.

SCRs clearly play an important role in the person's medical file. One RMO helpfully described a scenario where a young man was admitted to hospital when acutely unwell, with symptoms of a psychotic illness. This young man had an extensive psychiatric history extending to six volumes of medical files. The RMO explained that, while every twist and turn of the symptoms of the man's illness was documented in the medical files, the SCR is the only good source of a comprehensive personal and social history.

Statistics gathered in 2007-08 confirm that we and RMOs received limited information as to why SCRs were not in fact prepared. The lack of response to the statutory duty raises another important question. Are service users themselves informed when an SCR is being prepared or not? If not, are the reasons being explained to them? We believe individuals should always be advised when an SCR is being compiled, the reasons for this and who will receive the final report. If an SCR is not being prepared, we believe that best practice would be to inform individuals of the reason for this, unless there are compelling reasons not to.

One service user organisation assisted us with this guidance by asking for their members' views on SCRs. While not all of the individuals surveyed will have had experience of compulsory care and treatment

which triggers the preparation of an SCR, it is of interest that **of the 116 people who responded, only six members had ever heard of SCRs**. Some of those who had heard of them said that they had first heard of this report during Tribunal proceedings. While this is not a representative sample of service users, it seems to indicate a low level of awareness on the part of service users generally as to the nature and purpose of SCRs and when they are required.

### The challenge for management

In our view, the provision of SCRs needs to be prioritised to reflect the reality of the capacity of individual local authority's MHO services at any one point in time. Managers of MHO services must attempt to give some guidance to their MHOs as to how to prioritise the delivery of SCRs following relevant events. Individual MHOs are not in a position, nor is it their role, to have an overview of MHO resources. The MHO service is a local authority service and as such the authority should strive to achieve consistency, as well as good standards of practice in MHO service provision. It remains the responsibility of local authority managers to monitor the level and quality of SCR provision in their areas and the reasons given for deciding that a report would 'serve little or no practical purpose' (Code of Practice (page 165) and National Standards for MHO Services in Scotland; 7.8 in particular). Social work managers should strive to ensure that SCRs are targeted at people for whom they would provide most benefit.

### 3. Guidance for future practice

#### Social Circumstances Reports: Priorities

We have no doubt that MHOs are extremely busy, working from one tight timescale to the next. They have been under increasing pressure from increasing demands that have arisen from recent mental health and incapacity legislation. Despite workloads becoming more difficult to manage, MHOs and managers told us that decisions about whether or not to prepare an SCR often rest with the individual MHO. Consideration by management around when to prioritise these extremely important reports will help clarify the purpose of SCRs.

The aim of considering priorities is not to disadvantage any group. The aim is to give a steer towards a consistent, thoughtful and proactive consideration to the interpretation of what constitutes an SCR which may 'serve little or no practical purpose'. Prioritisation also allows precious resources to be used in the most efficient, targeted manner.

#### Good practice recommendations

##### **Recommendation 1**

- For a person who has no previous SCR on file, an SCR should always be completed within 21 days of initial relevant event. This is irrespective of whether the person is already known to mental health/learning disability services. In the exceptional – and unforeseen – circumstances where this does not happen, reasons must be clearly recorded in the SCR1 form.

##### **Recommendation 2**

- Where the detention order is revoked at an early stage, close attention should be paid to the circumstances of each case to determine where an SCR would be useful. For example, the relevant event may be representative of a pattern of short-term compulsory admissions, the causes of which need to be more closely examined and addressed. The SCR could still prove a very useful document and does not require to be a full, comprehensive report in such circumstances.

##### **Recommendation 3**

- In all cases where there has been a previous SCR, explicit reference ought to be made to the original SCR and the circumstances that have changed. This updated SCR should be provided in the same format i.e. there should not be different paperwork for an updated SCR. When making decisions about the provision of updated reports, priority ought to be given to reports for:

- children up to age 18 years
- people who have no permanent accommodation
- people who have no informal network of support or relevant others involved in their care
- circumstances involving offending behaviour
- any child protection issues
- where there are contentious issues or concerns that the MHO wishes to alert us to, in line with its statutory remit
- recent loss of employment
- recent bereavement
- breakdown or significant change in care/support arrangements
- where there are caring responsibilities
- victim of assault/exploitation
- incidents of serious self-harm.

#### **Recommendation 4**

- An annually updated SCR should be provided by the designated MHO for all people subject to long term detentions. Exceptions to this would be where there are agreed alternative review arrangements in place e.g. Care Programme Approach reviews that involve MHOs or MHO reports prepared to support decisions to extend/vary orders.

#### **Recommendation 5**

- Where a decision is made not to prepare an SCR, the reasons for this ought to be communicated to the service user in a format and at a time appropriate to the person's needs.

The final two recommendations are directed at managers of MHO services in particular:

#### **Recommendation 6**

- Local authority managers of MHO services should have governance arrangements in place to ensure that they are aware of both the quality and content of SCRs, as well as how SCRs are being prioritised within the service, so that local MHO practice is in line with the law and the associated regulation on SCR content, the Code of Practice and this guidance.

#### **Recommendation 7**

- Leaflet information should be developed to inform service users and carers of the value, purpose and audience of SCR reports and when they are required.

#### **Recommendation 8**

- Local authorities should develop protocols with local Sheriff Courts to ensure that requests for SCRs by the court are made directly to a specified person within the local authority.

