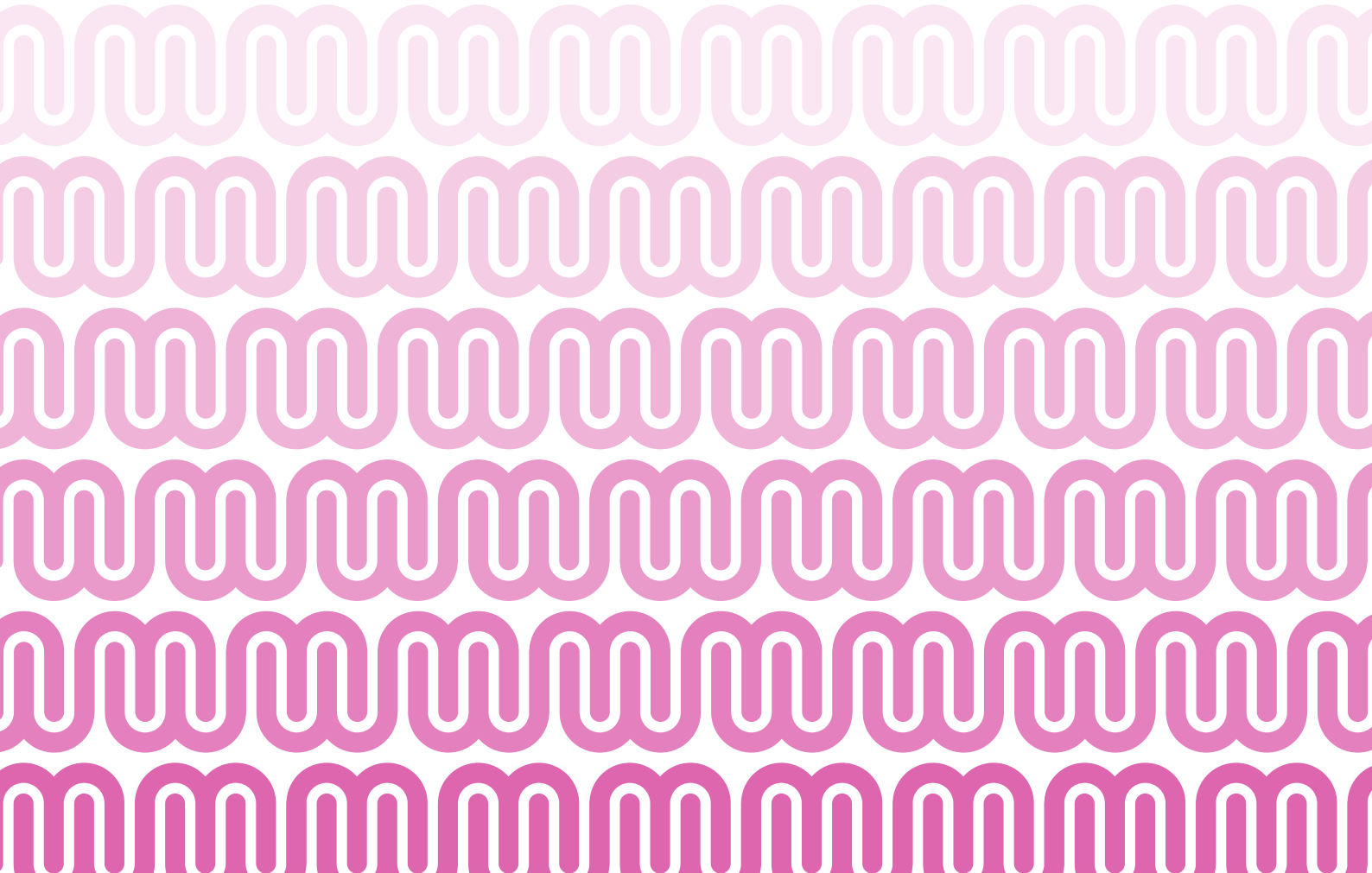
mental welfare commission for scotland

Social circumstances reports (SCRs)

Good practice guide

April 2022



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

This good practice guide was first issued in 2009 and was updated in 2022.

Contents

Background to this guidance

The Mental Welfare Commission published good practice guidance in relation to social circumstances reports (SCRs) in 2009 following consultation with relevant stakeholders. At that time, it was identified that the provision of SCRs was an area of practice where practitioners and managers had difficulty in achieving consistency in the circumstances in which Responsible Medical Officers (RMOs) and the Mental Welfare Commission ('the Commission') could expect a report to be prepared.

The Mental Health (Care and Treatment)(Scotland) Act 2003 ('the 2003 Act') extended the duties and responsibilities of mental health officers (MHOs), one of which required the MHO to produce an SCR under section 231 of the Act. An MHO is regarded as having the 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.

With the implementation of self-directed support[1], these options have increased further and could offer a real alternative to detention in hospital. However, there remains a downward trend in completion rates of SCRs and therefore a missed opportunity for this analysis by the MHO which could impact on outcomes for the adult at a crucial time in their lives.

The Commission fully recognises that when the 2003 Act was implemented, demands on MHO services were significantly less than they are currently and while the provision of SCRs remains as relevant, MHO capacity to provide them continues to reduce year on year as competing demands rise.

Our Mental Health Act Monitoring Report in 2019 offered a comparison of SCR provision over the previous ten years and noted that the completion of SCRs in relation to short term detention certificates (STDCs) continued this downward trend from 44% to 37% across Scotland as a whole. The report also highlighted that there is a significant variation in the completion of SCRs across Scotland.

We would wish to take this opportunity to remind local authorities (Health and Social Care Partnerships) of their duties under legislation to designate MHOs for each person's case (s.229 the 2003 Act) and to appoint sufficient MHOs for the purpose of discharging statutory functions (s.32 the 2003 Act).

As far back as 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, or no practical purpose" and this expectation remains relevant today.

[1] Social Care (Self-directed Support) Scotland Act 2013

Having reviewed our 2009 good practice SCR guidance (which was based on stakeholder feed-back at that time) we find that practice remains unchanged in 2022 and the original guidance remains fit for purpose. We are therefore taking the opportunity to repeat the content of our good practice guide and will be looking to local authorities, supported by Health and Social Care Partnerships, to revisit the progress they have made against the original eight recommendations.

Whilst our work on SCRs was originally informed by and directed at practitioners and managers, our guidance may also be of use to people subject to an order under the 2003 Act, carers, relatives and advocacy services.

Social circumstances reports in context

The implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) 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. As stated previously, an MHO, as a qualified and experienced social worker, 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 concerns about the low provision of SCRs in practice.

The 2003 Act defines the 'relevant events' (section 232(1)) that trigger the requirement for an MHO to prepare an SCR for the person's Responsible Medical Officer (RMO) and the Mental Welfare Commission.

An MHO need not comply with this requirement where it is considered 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 person's RMO and the Commission.

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.

The recording of the reasons why an SCR is not compiled also allows for RMOs and the Commission to perhaps disagree and explain that they, in fact, would find a report helpful. Unfortunately, the underreporting 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 in 2009. The Commission's 2009 guidance therefore aimed to help enhance the quality of reports and achieve greater consistency in the circumstances in which the Commission and RMOs could expect to see an SCR.

Legislative basis

The previous 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 in the 1984 Act, but were regarded as good practice. The majority of SCRs provided at that time were done on the basis of this good practice, rather than statutory requirement.

The 2003 Act consolidated this good practice into **a statutory duty**. Section 231 states that "where a relevant event occurs in respect of a patient, the mental health officer shall, before the expiry of the period of 21 days beginning with the day which the event occurs –

a) prepare in respect of the patient a social circumstances report; and
b) send a copy of the report to –
   (i) the patient's Responsible Medical Officer; and
   (ii) the Commission."

The Commission welcomed this change and reported an initial increase of over 50% in the provision of SCRs compared to the number provided under the 1984 Act.

The exception to the provision of an SCR is found in Section 231 (2) which is where the MHO considers that an SCR would serve little, or no, practical purpose. In this instance notification of this decision requires to be sent to the RMO and the Commission.

In 2009, 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 and this, in turn, led to different practices across different local authorities.

It was our view in 2009 that MHOs needed a framework to assist them when using their discretion about whether or not an SCR is produced. This not only establishes a degree of practice consistency but also clarifies for individuals who have been detained in hospital what they can expect as part of the detention process. Our view has not changed.

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 an individual 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 may not yield significant new information about the person. As such, the requirement only serves to undermine compliance with the Act. A strategic approach would be helpful in supporting MHOs to provide the SCR at the most appropriate and relevant point in the person's journey.

Whilst we question the value of three SCRs 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 SCRs 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 cannot 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.

Practitioners should note when preparing an SCR for relevant events under criminal proceedings, that additional considerations are required. For details of these please refer to the Code of Practice.[2]

[2] Mental Health (Care and Treatment)(Scotland) Act 2003 Code of Practice Volume 3- Chapter 6 section 106

The purpose of an SCR

The Mental Health Act 2003: Code of Practice (Volume 1) highlights the importance of SCRs 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. This intended purpose of an SCR appears to have been lost in current processes and there are instances when an SCR is completed after a detention has progressed from a short term detention certificate (STDC) to a compulsory treatment order (CTO).

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 health condition; and, to investigate a person's situation where they live alone and are unable to look after themselves, their property or financial affairs. SCRs 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.

The Commission reads SCRs as soon as we receive them if directed to do so by a covering letter from the MHO. The SCR is an extremely important document which should examine the interaction of an individual's social and family circumstances with their mental health condition. 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. With the increased flexibility and choice available under self-directed support legislation, the SCR can consider the full range of possible alternatives to further detention.

The SCR will also examine which compulsory measures, if any, will underpin the person's future care and treatment and if the care and treatment requires to be delivered within a hospital or a community setting.

In addition, the SCR will help to paint a more rounded picture of the person as a unique individual.

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 SCRs. Risk assessment and management plans should be considered as part of this process not just in relation to the compulsion itself and the 2003 criteria but also in terms of looking at alternatives to detention in hospital and how risk will be managed at home.

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.

Current practice

As discussed earlier we have seen a steady decline in the provision of SCRs and SCR 1s which detail why a report would "serve little, or no practical purpose" so it is difficult to say with any certainty why an SCR is not provided at relevant events.

In terms of some of the reasons given for the non-completion of SCRs these varied widely.

We hear in some instances that an SCR was not compiled because the STDC was revoked or there were no plans to progress to a CTO and although there is an acknowledgement that this might not be a priority for an MHO, the analysis of the person's circumstances which led to this relevant event may well offer an insight into what supports are required to ensure further measures under the Mental Health Act are not required.

Often there is a reference to an earlier SCR being available. MHOs at this stage should consider and record if the earlier SCR fully reflects the person's circumstances and that there are no material changes in their needs or presentation which would merit further consideration.

A regularly reported reason for the non-provision of an SCR is that the person is well known to services. While this may be the case, practitioners should be alert to a potential for complacency in service provision and an SCR could well provide an opportunity to revisit and review circumstances and where appropriate, respond in a different way. This response also appears to lack recognition of the value of the processes involved in preparing an SCR.

One of the most common reasons for non-completion of SCRs is that a CTO application is in progress and a view that this represents a duplication in work. Again practitioners should be reminded of the different purposes of the SCR as a means of considering the need for further statutory intervention. The Code of Practice explains the difference between an SCR and the reports required for a CTO application. Their purposes are distinct.

Finally one of the most reported reasons for the non-completion of the SCR is due to workload pressures. Local authorities are reminded that this is a **statutory duty** and they have an obligation to appoint sufficient numbers of suitably qualified staff to fulfil this legal requirement.

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

In some cases, organisational matters limit the opportunity to allocate casework in good time. Delays in relation to communication from courts are often highlighted as particularly

problematic where SCRs were required for individuals involved in criminal proceedings. Protocols require to be in place to address such problems where they exist.

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 Health and Social Care Partnership (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.

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 at the Commission.

Where we do receive a SCR the quality of the report 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).

Previous 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 person is well known to RMOs, simply because the person 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 was the only good source of a comprehensive personal and social history.

While the Commission and the RMO may be informed of the reasons why a report has not been compiled, this raises another important question - are the individuals themselves informed when an SCR is being prepared or not? 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.

The challenge for management, in our view, is that 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 (often within a health and social care partnership (HSCP)) 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 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).

Managers should strive to ensure that SCRs are targeted at people for whom they would provide most benefit and local auditing could confirm if the use of the limited MHO resource is being maximised.

Good practice recommendations

We are fully aware of the demands on the MHO workforce currently and the national commitment to train more MHOs.

The aim of considering priorities in relation to SCR provision 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, consistent and targeted manner. We therefore repeat our original recommendations of 2009 as follows:

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 and young people 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;
- any adult support and protection issues;
- where there are contentious issues or concerns that the MHO wishes to alert the Commission to, in line with our 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 orders. 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 person who has been detained in a format and at a time appropriate to the person's needs.

Recommendation 6

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 the Commission's guidance.

Recommendation 7

Leaflet information should be developed to inform individuals 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 area.

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